

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08281

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>01</u> <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial Hospital</u>				e. STREET ADDRESS <u>921 Nichols Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>(Baby boy)</u> <u>Alexander</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>13</u> <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-61</u>	9. AGE (In years last birthday) yrs. <u>0</u> Months <u>6</u> Days <u>30</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Arthur Wallace Alexander</u>			
14. MOTHER'S MAIDEN NAME <u>Barbara Mae Hartman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth (25 wks)</u> DUE TO (b) <u>Respiratory failure</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hrs.</u> <u>12 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 13</u> to <u>July 13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 13</u> , 19 <u>61</u> , and that death occurred at <u>7:25</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>R. S. McCeney</u>				M.D. 22c. PHYSICIAN'S NAME (Type) <u>R. S. McCeney, M. D.</u>		22b. DATE SIGNED	
22d. ADDRESS <u>402 Main Street, Laurel, Maryland</u>				22e. REC'D BY REGISTRAR DATE <u>JUL 20 '61</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>				22g. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(10)
(3)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8289

CERTIFICATE OF DEATH

08282

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 2 mo., 14 da		d. STREET ADDRESS 1243 10th St., N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert H. Askins		4. DATE OF DEATH Month 7 Day 31 Year 61	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/04
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Standard Paving Co. Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Askins		14. MOTHER'S MAIDEN NAME Mary Lincoln	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-03-9265	
17. INFORMANT Decedent		Address -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). Pulmonary embolus 465X DUE TO (b) - Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Carcinoma of left lung, metastatic, primary site unknown, resected left pneumonectomy, 7/5/61; pyloroplasty, 7/26/61			
20a. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20c. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/17 5:00, 1961 to 7/31, 1961, that (I) (we) last saw the deceased alive on 7/31, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 7/31/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 31st 1961		23b. DATE THEREOF 7/31/61	
23c. NAME OF CEMETERY OR CREMATORY Ash Memorial		23d. LOCATION (City, town or county) (State) Landey Springs, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. B. Grogg		25a. REC'D BY REGISTRAR AUG 4 '61	
25b. REGISTRAR'S SIGNATURE W. H. Bacon		25c. ADDRESS 1722 7th St. N.W.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8290

CERTIFICATE OF DEATH

Reg. Dist. No.

08283

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ad-Sacorda 2601 CHEVERLY AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle J. Last Augusterfer		4. DATE OF DEATH Month July Day 19 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.	11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN AUGUSTERFER	
14. MOTHER'S MAIDEN NAME SUSAN GADDIS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. MISS RITA M. AUGUSTERFER same as #		17. ADDRESS MISS RITA M. AUGUSTERFER same as #	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO 5 yrs. (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/7 , 19 54 to 7/19 , 19 61 , that I last saw the deceased alive on 7/15 , 19 61 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Cimenau		ADDRESS (Street, city or town, state) 3503 Penny 31	
PHYSICIAN'S NAME (Type) Norman Donat Cimenau		DATE SIGNED 7/19/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Collins		24. REC'D BY REGISTRAR JUL 24 '61	
ADDRESS Wash. D.C.		25. REGISTRAR'S SIGNATURE Arthur S. Frank	
26. NAME OF DECEASED FRANCIS J. COLLINS		27. ADDRESS 3821 14th. St. N.W.	

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MEDICAL CERTIFICATION

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THE
OFFICE OF THE
SECRETARY OF THE
NAVY
WASHINGTON, D. C.
JANUARY 1, 1900
TO THE
HONORABLE
MEMBERS OF THE
NAVY
DEPARTMENT
FROM
THE
SECRETARY OF THE
NAVY
SIR,
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the proposed purchase of the land at the mouth of the River, and in reply to inform you that the same has been referred to the proper authorities for their consideration.
Very respectfully,
J. D. LONG
Secretary of the Navy

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8291
CERTIFICATE OF DEATH
08284

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 HOUR d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OHIO b. COUNTY HAMILTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CINCINNATI d. STREET ADDRESS 5842 POINTER LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LESLIE JEANNINE BACKHERMS				4. DATE OF DEATH Month Day Year JULY 7 19 61			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 MAY 1954	
9. AGE (In years lost birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ALVIN T BACKHERMS				14. MOTHER'S MAIDEN NAME SHIRLEY L BERNHARDT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 7 JULY 1961 to 7 JULY 1961 that we (we) last saw the deceased alive on 7 JULY 1961 , and that death occurred at 845A M, from the causes and on the date stated above.							
22a. SIGNATURE <i>John A. Moore</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7 JULY 61	
22c. PHYSICIAN'S NAME (Type) JOHN A MOORE, Major USAFMC				22d. ADDRESS USAF HOSP, ANDREWS AFB, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10 JULY 1961		23c. NAME OF CEMETERY OR CREMATORY CINCINNATI OHIO		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Kissali Funeral Home Inc</i>				ADDRESS 816 1st. N.E. DC 2		25a. REC'D BY REGISTRAR DATE JUL 10 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

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STATE OF NEW YORK

1897

(VI)

IN SENATE,
January 13, 1897.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN ANSWER TO A RESOLUTION
PASSED BY THE SENATE,
MAY 1, 1896.
ALBANY:
J. B. LANE, PRINTERS,
1897.

CHIEF CLERK

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8292

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08285

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside			
f. STREET ADDRESS 1 1412 52nd PLACE Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Melvin Charles Bacon				4. DATE OF DEATH Month Day Year July 30 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21st, 1922	
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Helper				10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Carl W. Bacon				14. MOTHER'S MAIDEN NAME Esther Wade Pearson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 11		17. INFORMANT Unknown		Address Warren H. Bacon, 5202--N--St., Hillside, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Hemorrhagic Pancreatitis DUE TO (c) Chronic Alcoholism-Multiple Contusions & Echymoses-Cerebral Edema Acute Alcoholic Intoxication and delirium Tremens							INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from July 28 19 61, to July 30 19 61, that (we) last saw the deceased alive on July 30 19 61, and that death occurred at 5:45 AM from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 2/30/61			
22c. PHYSICIAN'S NAME (Type) Francis X. Carillo M.D.				22d. ADDRESS 1013 University Blvd., Silver Spring 1013 Univ. Blvd. E. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. Chambers Co. Inc. 517 11-56 N. W. WASH. D. C.				25a. REC'D BY REGISTRAR AUG 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krasa	

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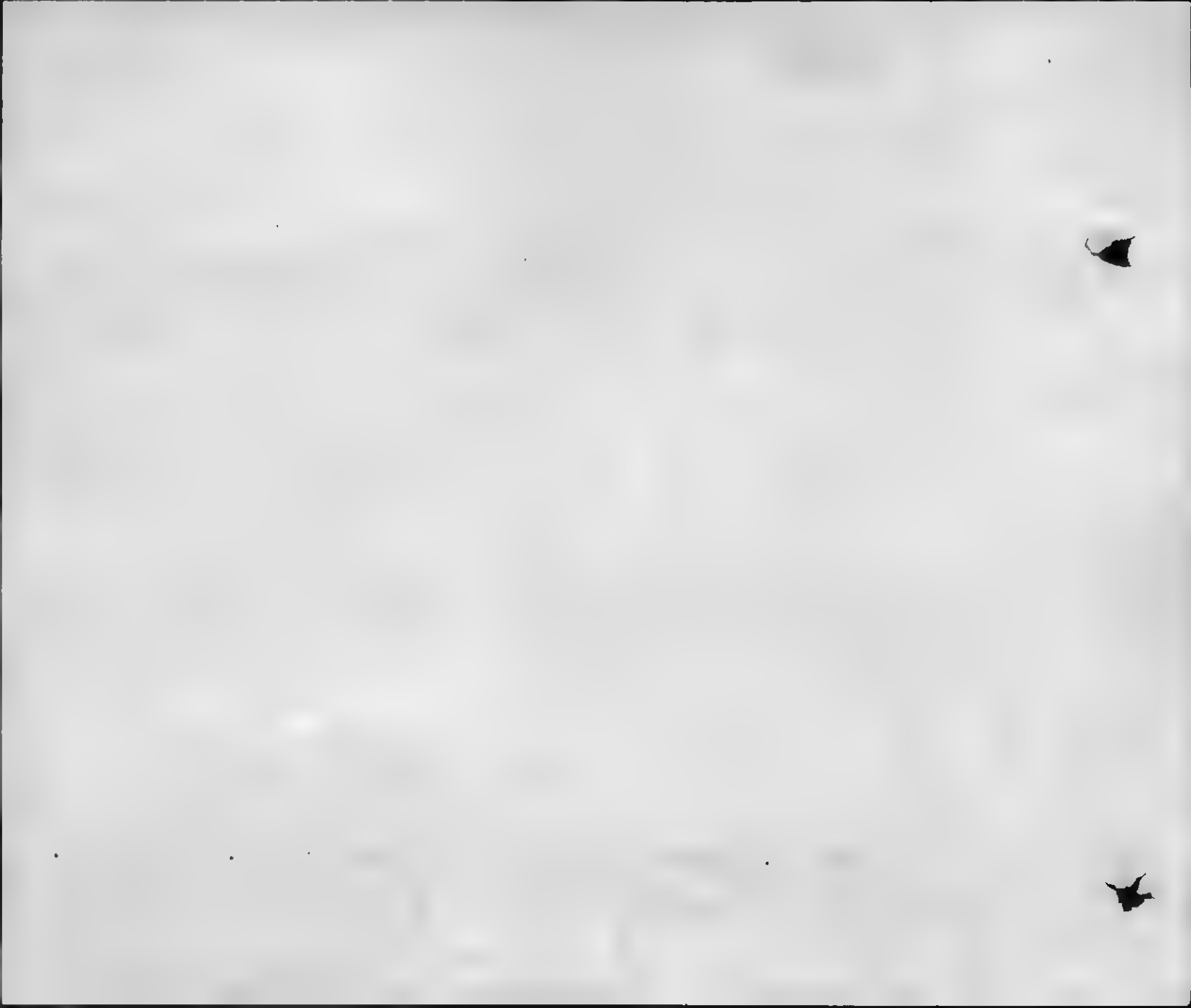
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8293											
CERTIFICATE OF DEATH											
08286											
1. PLACE OF DEATH a. COUNTY <u>Prince George</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>28 hrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Memorial</u>				d. STREET ADDRESS <u>13922 Oglethorpe Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baker, Mary Katherine</u>				f. DATE OF DEATH <u>July 7 1961</u>							
5. SEX <u>Fe</u>				6. COLOR OR RACE <u>White</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 4, 1878</u>				9. AGE (In years last birthday) <u>83 yrs.</u>				10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Richard Loveless</u>				14. MOTHER'S MAIDEN NAME <u>Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mae Gosnell (daughter)</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 42) } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Dehydration</u> (c), stating the underlying cause last. } DUE TO <u>Anorexia and old age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e). <u>Old age</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> 19 <u>61</u> to <u>7-7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-7</u> 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Ronald E. Krum</u>											
22b. DATE SIGNED <u>7-7-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Ronald E. Krum, MD</u>											
22d. ADDRESS <u>4404 Queensbury Road, Riverdale, Md.</u>											
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>											
23b. DATE THEREOF <u>July 10, 1961</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery Laurel Md.</u>											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Spencer L. Donaldson</u>											
25a. RECD BY REGISTRAR <u>JUL 13 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Krum</u>											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9 & 14 F.L.L.G.-1 7/24/61 iwk

8294

CERTIFICATE OF DEATH

Reg. Dist. No. 08287

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Rural (Friendly)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9035 Old Fort Rd. E</u>		e. STREET ADDRESS <u>9035 Old Fort Rd. E</u>	
3. NAME OF DECEASED (Type or print) <u>Baile Annie</u>		4. DATE OF DEATH <u>July 14 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15 86 '74</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Prince G. Co. Md.</u>	
13. FATHER'S NAME <u>Robert Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Agness Beck, Daughter, 9035 Old Fort Rd.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>445X Acute Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Gouty Arthritis</u> (c) <u>Hypertensive Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Art-Sclerosis & Hemiplegia 5 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-27 1961</u> , to <u>7-14 1961</u> , that I last saw the deceased alive on <u>7-12-61</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.		DATE SIGNED <u>7519 Broadview Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd, M.D.</u>		<u>Wash. 22, D.C. (P. Ho., Inc)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-18-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Ch. Ceme.</u>	22d. LOCATION (City, town or county) (State) <u>Friendly Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall Bros.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>	
ADDRESS <u>621 Fla. ave NW</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8295

CERTIFICATE OF DEATH

Reg. Dist. No. 02283

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6908-18th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HELENE ELAINE M.B. BALLEW		4. DATE OF DEATH Month Day Year July 30 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1913
9. AGE (In years lost half day) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk, Dept. Store	
11. BIRTHPLACE (State or foreign country) New York City N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Father Emmanuel Brigas		14. MOTHER'S MAIDEN NAME Catherine Ronalty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 135-03-6216	
17. INFORMANT Address alone		Helen L. Ballew, Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Carcinoma of Breast with Metastasis		INTERVAL BETWEEN ONSET AND DEATH 3-4 months 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1954, to July 30, 1961, that I last saw the deceased alive on July 28, 1961, and that death occurred at 5 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Troy M.D.		ADDRESS (Street, city or town, state) 7105 Reed Rd. DATE SIGNED	
PHYSICIAN'S NAME (Type) ROBERT B. TROY		Hyattsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/61	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE AUG 3 '61	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

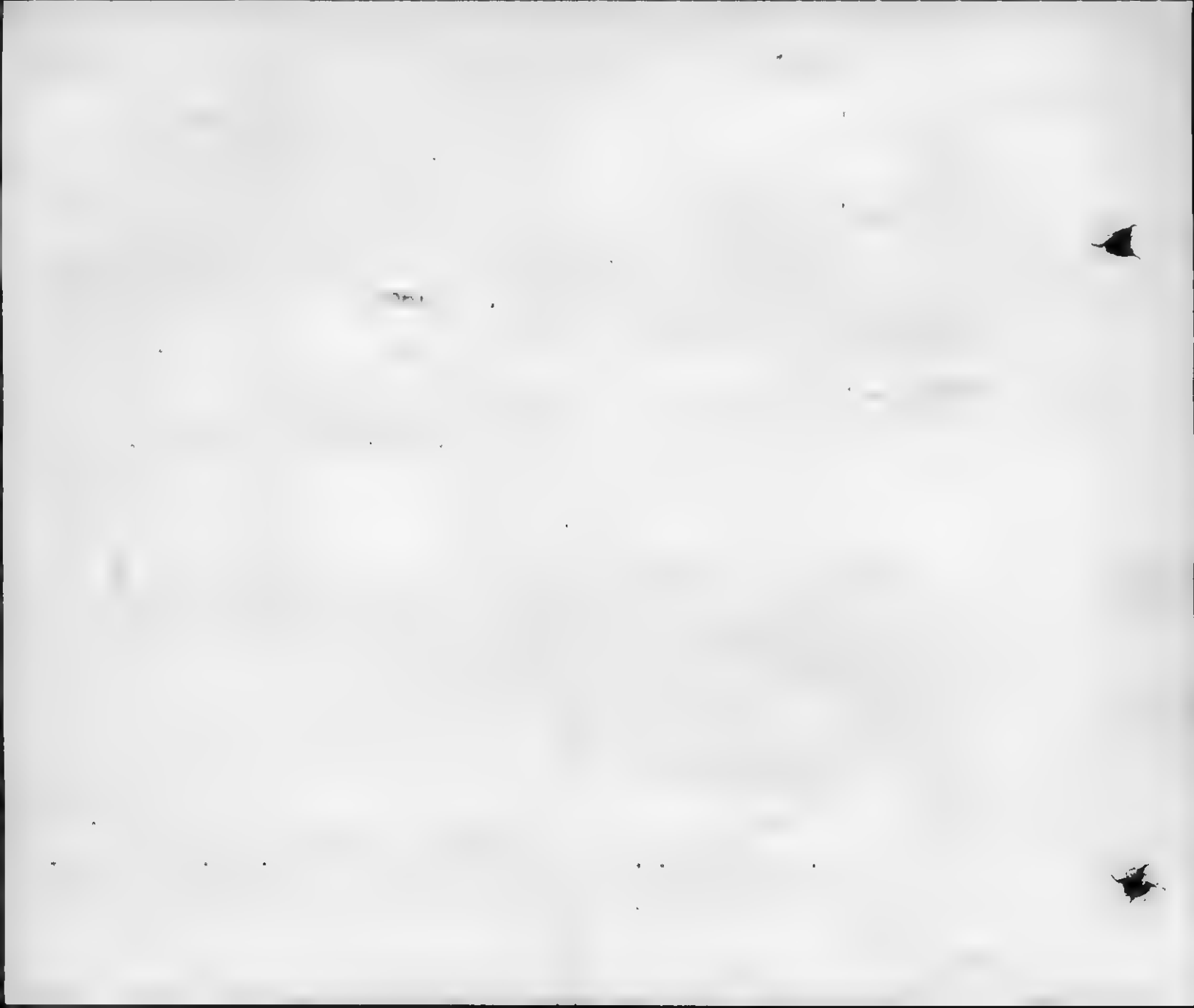
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8295

C8283

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 5410 40th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Bateman				4. DATE OF DEATH Month July Day 5 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1890	
9. AGE (In years last birthday) 71 yrs		10. AGE (In years last birthday) 71 yrs		11. AGE (In years last birthday) 71 yrs		12. AGE (In years last birthday) 71 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Henry W. Price				14. MOTHER'S MAIDEN NAME Cornelia Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO no		17. INFORMANT husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO (b) cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr 1 year 4 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) leukemia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JUN 1961 to July 5, 1961 , that (I) (we) last saw the deceased alive on July 5, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leon R. Levitsky, M.D.				22b. DATE SIGNED July 5, 1961			
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.				22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 7/7/61		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION (City, town, or county) (State) Washington, D.C.				23e. REC'D BY REGISTRAR DATE JUL 7 '61			
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901-14th St. N.W.				25b. REGISTRAR'S SIGNATURE John E. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

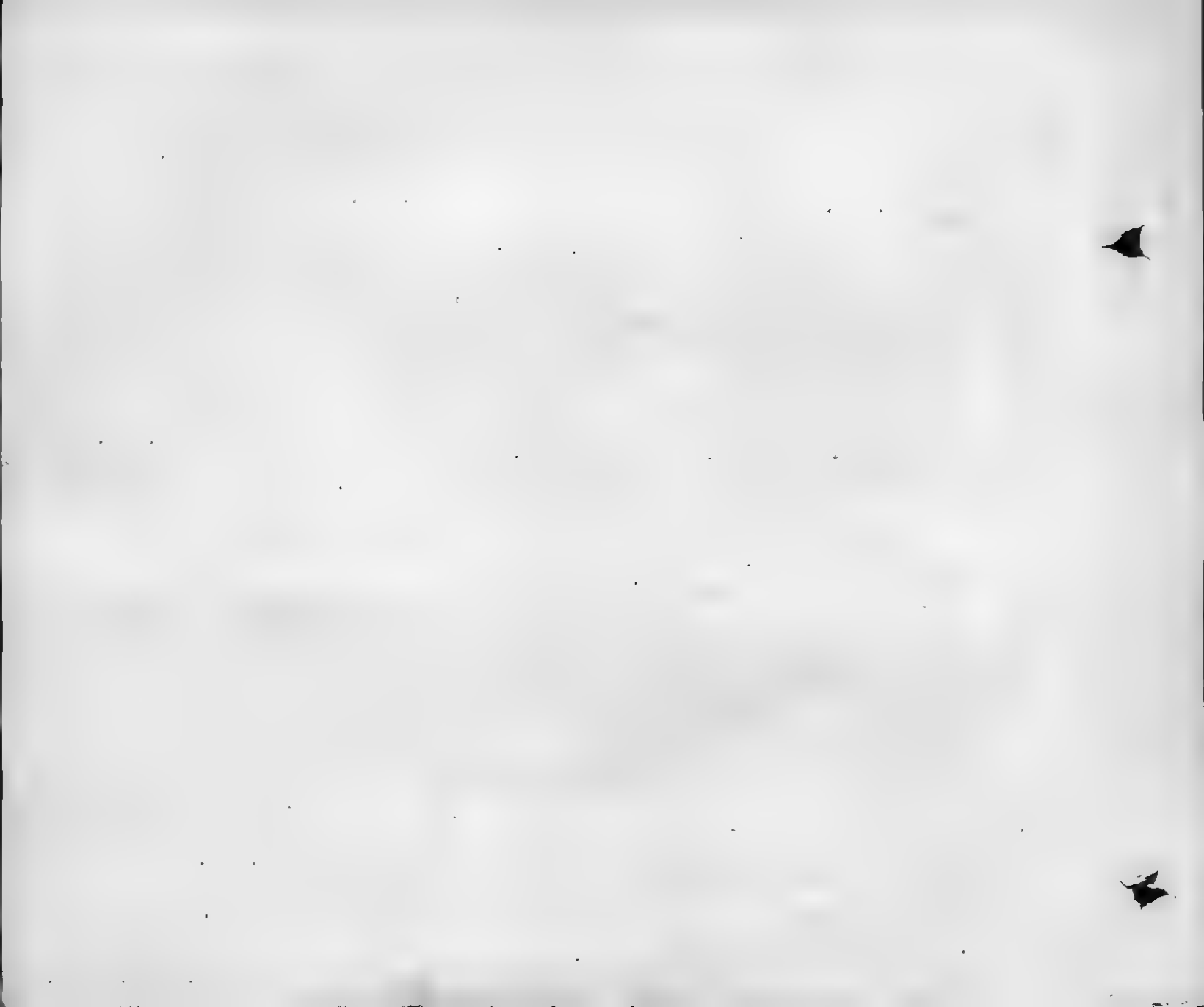
8297

CERTIFICATE OF DEATH

Reg. Dist. No. 08290

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie High Bridge Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie High Bridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowie, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Norman Henry Beckett				4. DATE OF DEATH Month Day Year July 16, 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 17, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agriculture		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Beckett				14. MOTHER'S MAIDEN NAME ? Pumphrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) no		16. SOCIAL SECURITY NO. 40		17. INFORMANT Address Eva Beckett High Bridge Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary artery occlusion with acute myocardial infarction - winter (b) Atherosclerotic Heart Disease Year (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 7/16, 1961, that I last saw the deceased alive on 7/15, 1961, and that death occurred at 528 M, from the causes and on the date stated above							DATE SIGNED
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS (Street, city or town, state) R F D Glenn Dale Md			
PHYSICIAN'S NAME (Type) H. James Kurtz				R F D Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/61		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE Jul 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

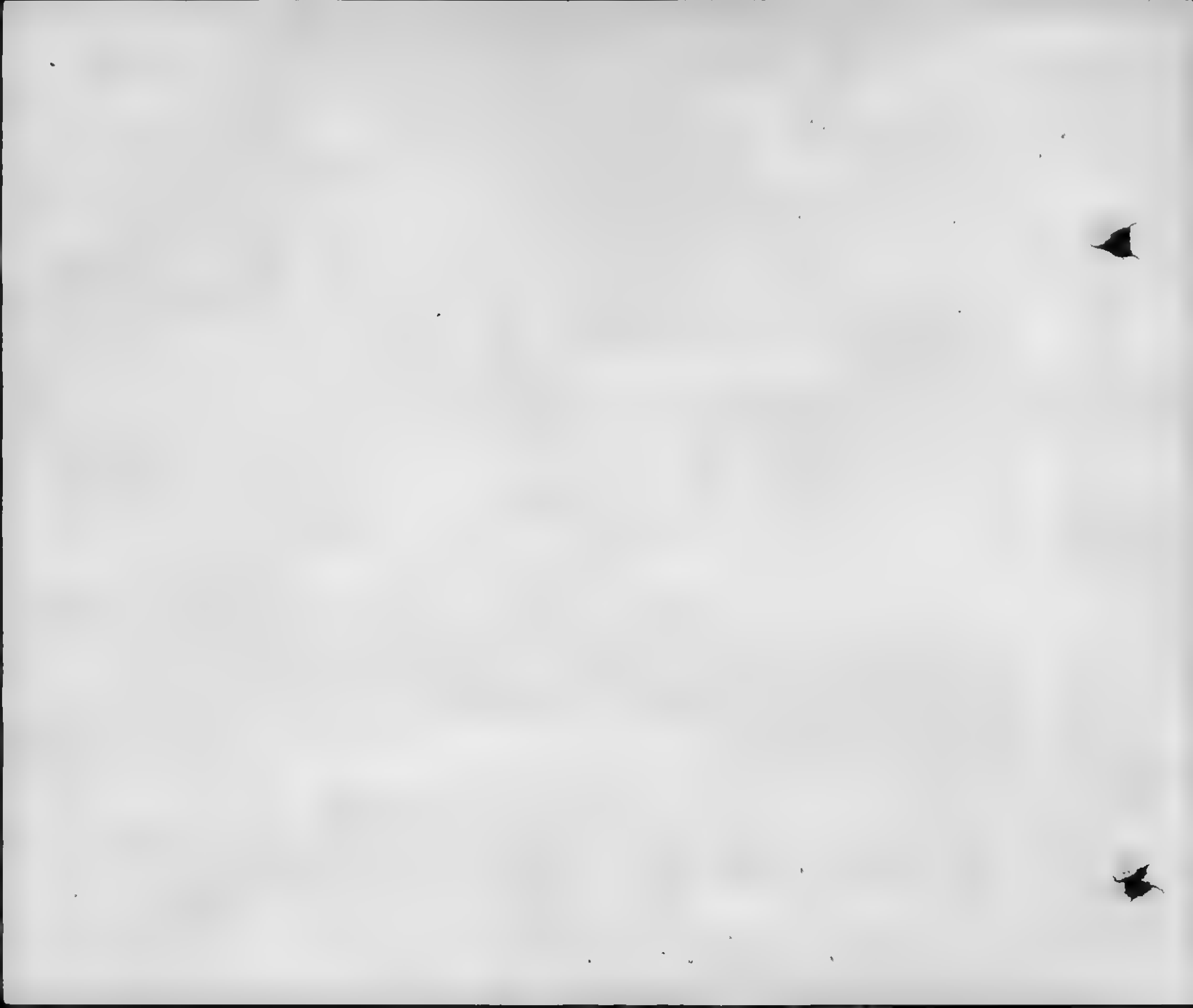
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8298

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08291

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admision) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard		4. DATE OF DEATH July 12 1961		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1938		9. AGE (In years, if UNDER 1 YEAR last birthday) Months Days Hours Min. 22/23 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. BIRTHPLACE (State or foreign country) North Carolina		12. MOTHER'S MAIDEN NAME Bell Armstrong		13. FATHER'S NAME Hammond Smith		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1		15. SOCIAL SECURITY NO.		16. INFORMANT Bell Armstrong		17. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		INTERVAL BETWEEN ONSET AND DEATH	
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		19d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19f. (City or town) (County) (State)		19g. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19h. DATE SIGNED 7/14/61			
20. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		21. ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		23. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		24. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		25. Address (Street, city, town, or county)		26. DATE SIGNED 7/14/61		27. REGISTRAR'S SIGNATURE Godwin Hart Cochran			
28. BURIAL, CREMATION, REMOVAL (Specify) 7/18/61 Burial		29. DATE THEREOF 7/18/61		30. NAME OF CEMETERY OR CREMATORY Spring Oak		31. LOCATION (City, town, or county) Godwin Hart Cochran		32. REGISTRAR'S SIGNATURE John T. Rhines		33. ADDRESS 3015-12th St. Wash DC		34. DATE JUL 19 1961		35. REGISTRAR'S SIGNATURE John T. Rhines			



8299

CERTIFICATE OF DEATH

Reg. Dist. No. 08292

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9205-3rd Street</u>				d. STREET ADDRESS <u>6120-54th Avenue</u>				
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>RUTH</u> Last <u>BEVANS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>12</u> Year <u>1961</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 25, 1899</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE MELVIN LITTLE</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN AUGUSTA GREENWELL</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-14-3373</u>		17. INFORMANT Address <u> </u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X Carcinomatosis</u> DUE TO (b) <u>Carcinoma of rectum</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>September, 1946</u> to <u>July 12, 1961</u> , that I last saw the deceased alive on <u>July 11, 1961</u> , and that death occurred at <u>11:25 A.M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>C. Louis Mendel</u>				ADDRESS (Street, city or town, state) <u>4506 COLLEGE AVE</u> DATE SIGNED <u>7/12/61</u>				
PHYSICIAN'S NAME (Type) <u>C. LOUIS MENDEL</u>				<u>COLLEGE PARK MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/14/61</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8300

08293

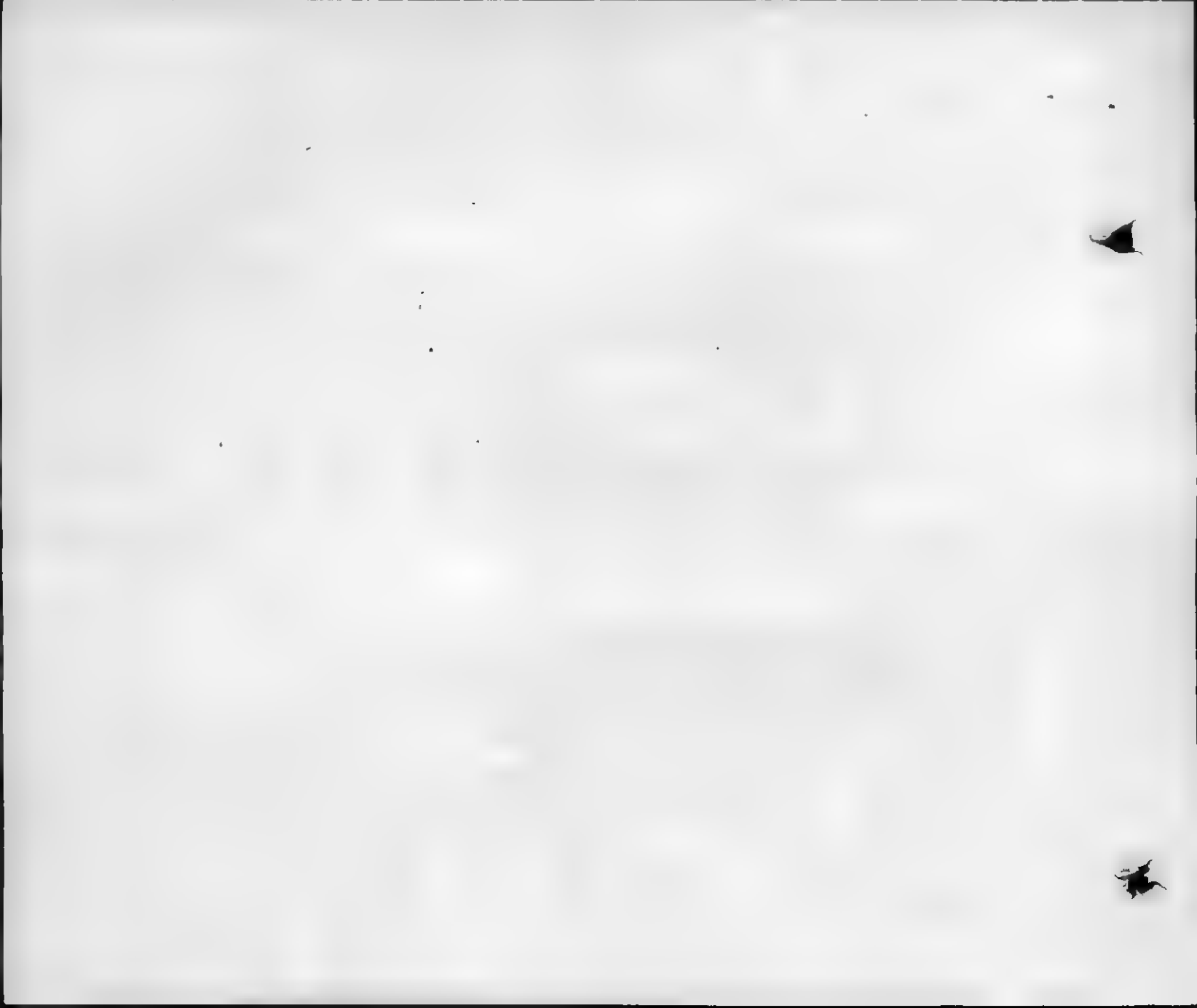
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 6 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills, Maryland			
d. STREET ADDRESS 5009- Spring Drive S.E.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) LILLIAN KING BIRD				4 DATE OF DEATH July 7th 1961			
5. SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20-July 1870	
9. AGE (In years lost birthday) 90 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Martin Luther King				14 MOTHER'S MAIDEN NAME Annie Tibbetts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) []		16 SOCIAL SECURITY NO []		17. INFORMANT Albert F. Bird Address Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis DUE TO arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) [] DUE TO (c) []							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phenothiazine Arteriosclerosis							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 2, 1961 to July 7, 1961 , that (I) (we) last saw the deceased alive on July 2, 1961 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Lewis Parker				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7-7-61	
22c. PHYSICIAN'S NAME (Type) Lewis PARKER				22d. ADDRESS 52nd St New York 18 SE			
23a BURIAL, CREMAT OR REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-61		23c. NAME OF CEMETERY OR CREMATORY Edgewood Cemetery		23d. LOCATION (City, town, or county) (State) Nashua New Hampshire	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				1661 Good Hope Road SE Washington DC		25a REC'D BY REGISTRAR DATE JUL 10 '61	
				25b. REGISTRAR'S SIGNATURE Carl S. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8301

08294

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY (In days)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General

3. NAME OF DECEASED
(Type or print)

First

Mary

Middle

E.

Last

Bollman

4. DATE OF DEATH

Month

Day

Year

July

25

1961

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

April 2, 1889

9. AGE (In years)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

72 yrs.

Months

Days

Hours

M n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Not employed

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JAMES W. BURDINE

14. MOTHER'S MAIDEN NAME

JOSEPHINE CONNORS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

HARVEY L. SUPPLE

Address

SAME AS #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUETO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUETO

(c)

Congestive Heart Failure
Hypertensive A-S. C-V Disease

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Diabetes mellitus; bronchopneumonia

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from 7/24 to 7/25, 1961, that (I) (we) last saw the deceased alive on 7/24, 1961, and that death occurred at 7:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Leon L. Gallin

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

7/25/61

22c. PHYSICIAN'S NAME (Type)

Leon L. Gallin M.D.

22d. ADDRESS

W. Hyattsville

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

7-28-1961

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION (City, town or county)

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

W. W. Chambers Co. Inc.

ADDRESS

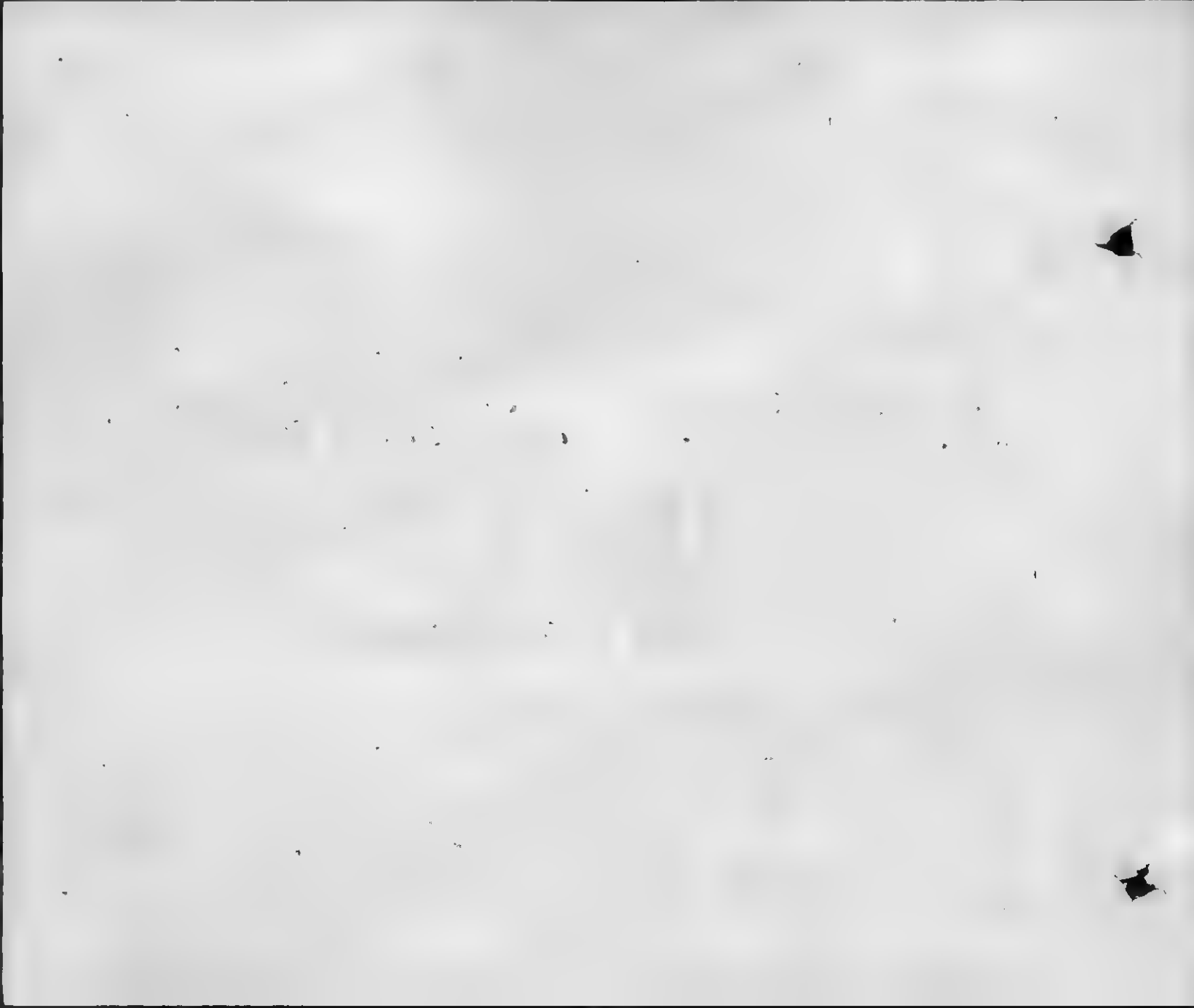
5801 Cleveland Ave
Baltimore, Md

25a. REC'D BY REG. STRAR

DATE JUL 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

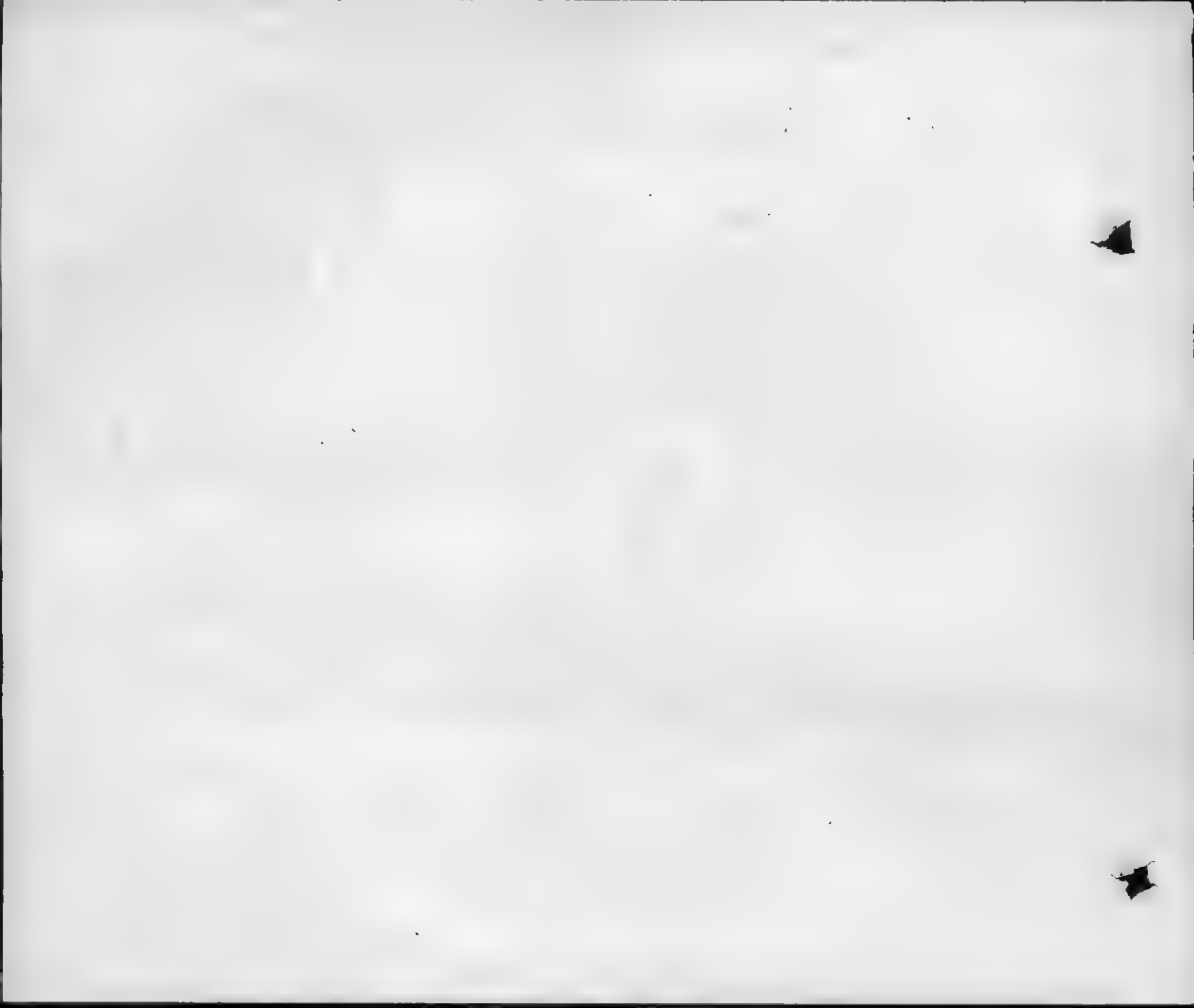
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
15M 9/59

8302 **CERTIFICATE OF DEATH** 08295
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>81 Lanham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1103 Snowden Place</u>				d. STREET ADDRESS <u>1103 Snowden Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Aubrey B. Brown</u>				4. DATE OF DEATH Month Day Year <u>July 15 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 5 1906</u> 9. AGE (In years last birthday) <u>55</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier Foreman Library of Congress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co. Md</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Brown</u>				14. MOTHER'S MAIDEN NAME <u>Ella Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>579-2235</u>		17. INFORMANT <u>Barbara J. Brown, Lanham, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Hypertension</u> DUE TO <u>Aortic Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9 A</u> . M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Isidoro Pierandree</u>				22b. DATE SIGNED <u>JUL 20 '61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lanham, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Willardson</u>				25a. REC'D BY REGISTRAR <u>JUL 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

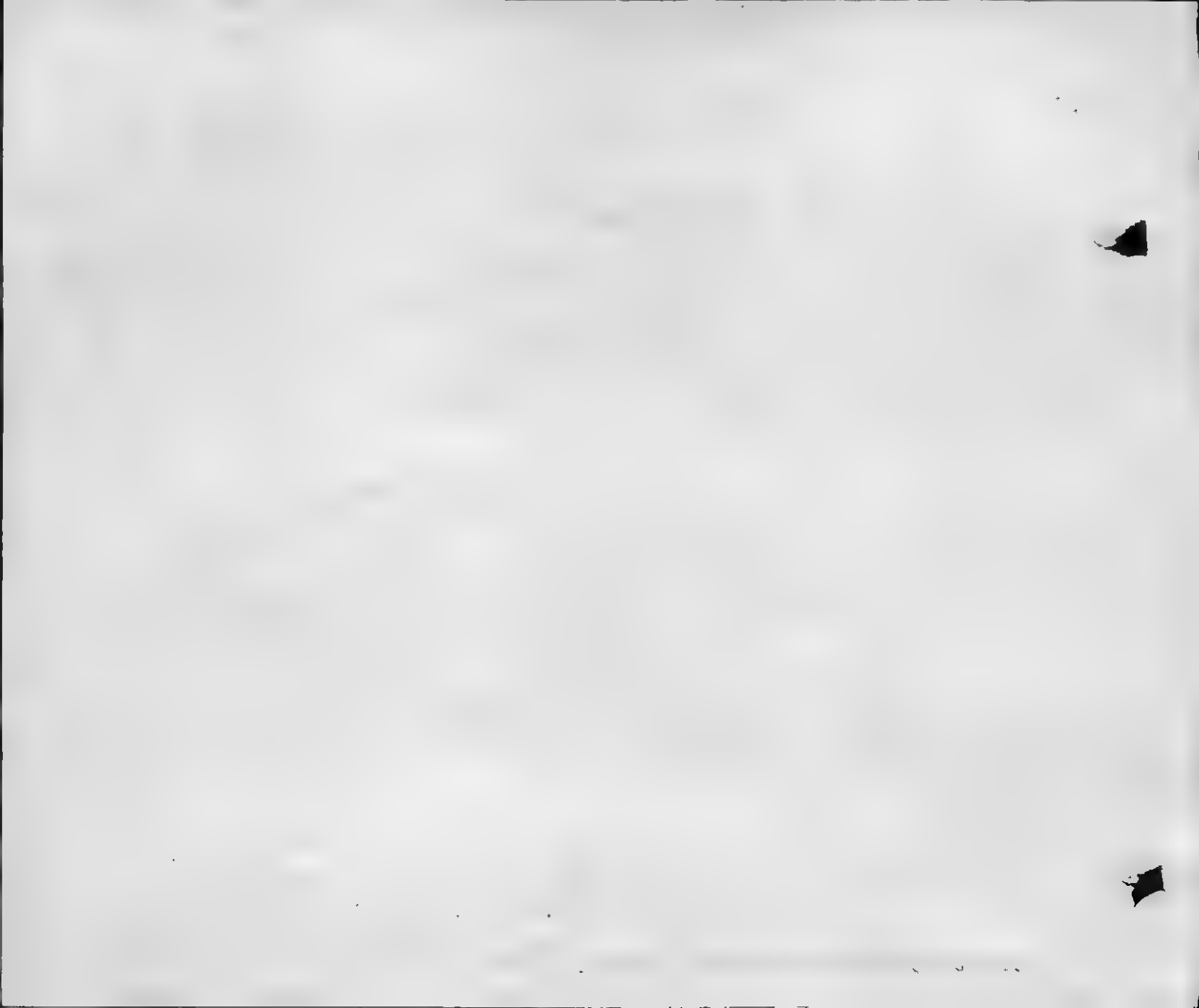
CERTIFICATE OF DEATH

8303

08296

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Gen. Hospital</u>		d. STREET ADDRESS <u>145 A Street</u>	
3. NAME OF DECEASED (Type or print) <u>Lewis C. Brown</u>		4. DATE OF DEATH <u>July 26 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13 1887</u> 73 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>General construction</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cornelius Brown</u>		14. MOTHER'S MAIDEN NAME <u>Thellie Goodale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mr. Eader Laurel, Md.</u>	
17. INFORMANT <u>Mr. Eader Laurel, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema - Congestive Heart Failure</u> 31 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubitus Ulcer - Severe</u> DUE TO (c) <u>C.V.A. - Possible Thrombosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>5-10</u> , 19 <u>61</u> , to <u>7-</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W.L. Etienne</u>		22b. DATE SIGNED <u>7-27-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		22d. ADDRESS <u>College BK, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 29, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flanders Cemetery</u>	23d. LOCATION (City, town or county) <u>Riverside New York</u> (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sanderson Laurel, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 31 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>



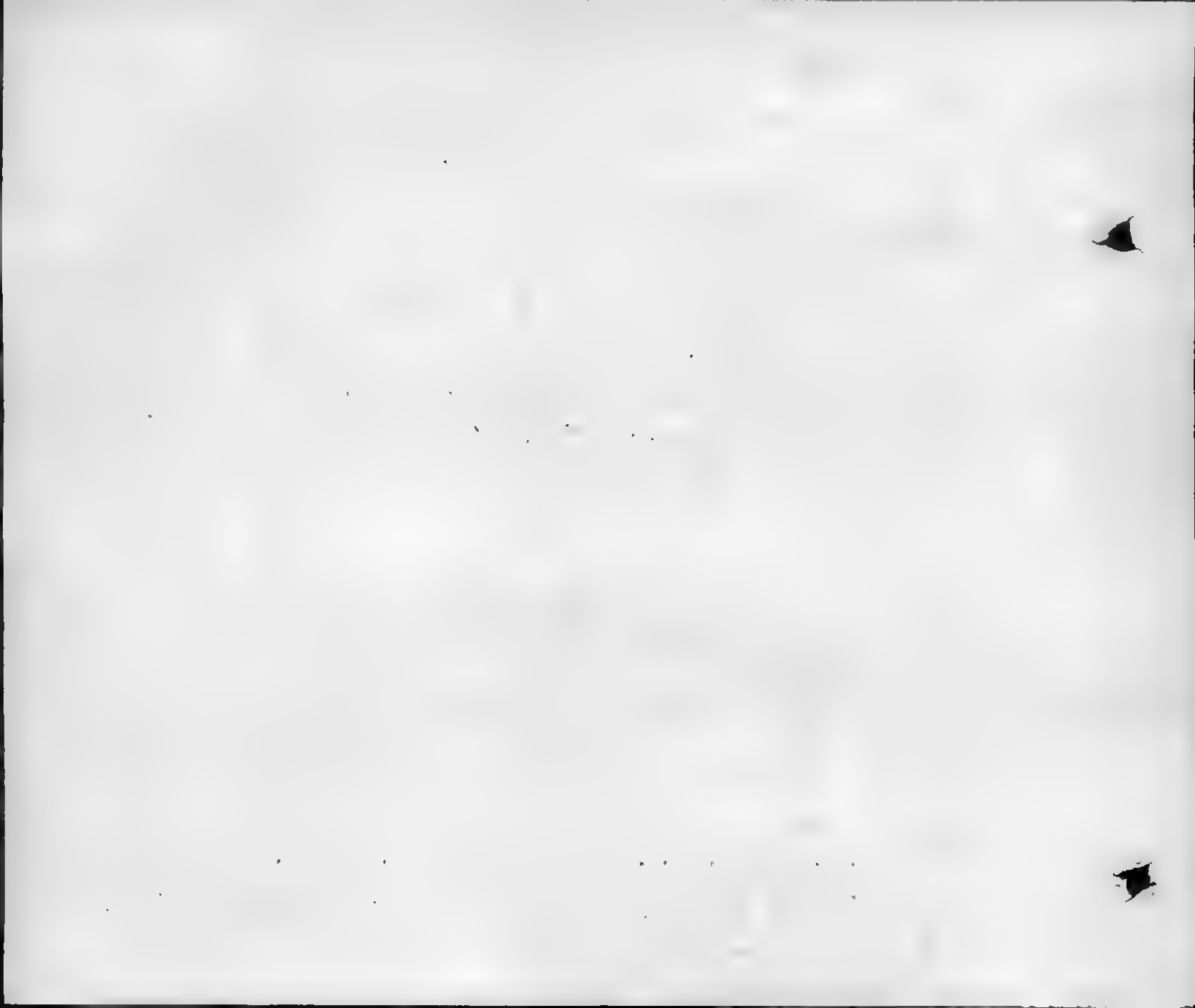
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8304

00297

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 5410 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howell S Brunson				4. DATE OF DEATH Month Day Year July 22 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Jan 1898		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Engraver		10b. KIND OF BUSINESS OR INDUSTRY STAR NEWS PAPER		11. BIRTHPLACE (State or foreign country) DAISY GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME BENJAMIN BRUNSON				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes WAR II		16. SOCIAL SECURITY NO. 257-10-3901		17. INFORMANT MRS. BELVA R. BRUNSON		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 11/21 DUE TO Multiple pulm. emboli (b) Bro n charge core (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7-11 1961 to 7-22 1961, that (I) (we) last saw the deceased alive on 7/22/1961, and that death occurred on 7/23/61 from the causes and on the date stated above. 22a. SIGNATURE George Hageage 22b. PHYSICIAN'S NAME (Type) Dr. G. Hageage., M.D. 22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Mt. Rainier., Md 22e. DATE SIGNED 7/23/61 23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL 23b. DATE THEREOF JULY 28, 1961 23c. NAME OF CEMETERY OR CREMATORY Pembroke Cem. 23d. LOCATION (City, town, or county) (State) Pembroke, Georgia 24. FUNERAL DIRECTOR'S SIGNATURE Will. Chambers Co. Riverdale, Md 25a. REC'D BY REGISTRAR DATE JUL 26 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Huns							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon payers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8305

08298

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

6 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

College Park

d. STREET ADDRESS

5510 Cleveland Avenue

IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

DATE OF DEATH

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

Buffloe

8. DATE OF BIRTH

May 9, 1902

9. AGE (In years, If UNDER 18, last birthday)

59 yrs.

10. MONTHS

Days

Hours

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chambermaid Hotel

10b. KIND OF BUSINESS OR INDUSTRY

Raleigh Hotel

11. BIRTHPLACE (County & State, or foreign country)

Gibson, North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Buchanan

14. MOTHER'S MAIDEN NAME

Rosa Flour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

College Park, Md

Mrs. Inez Campbell

5510 Cleveland Ave

INTERVAL BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Thrombosis

Myocardial Infarction

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

Cerebral infarction

DUE TO

Arteriosclerosis

14 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1961, to July 7, 1961, that (I) (we) last saw the deceased alive on July 7, 1961, and that death occurred at 9:00 AM, from the causes and on the date stated above.

22a. SIGNATURE

W. E. Etienne

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

W. E. ETIENNE

22d. ADDRESS

College Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Shipping

23b. DATE THEREOF

7/10/61

23c. NAME OF CEMETERY OR CREMATORY

Lightner Funeral Home

23d. LOCATION (City, town or county)

Raleigh, North Carolina

24. FUNERAL DIRECTOR'S SIGNATURE

Alexander S. Hays

ADDRESS

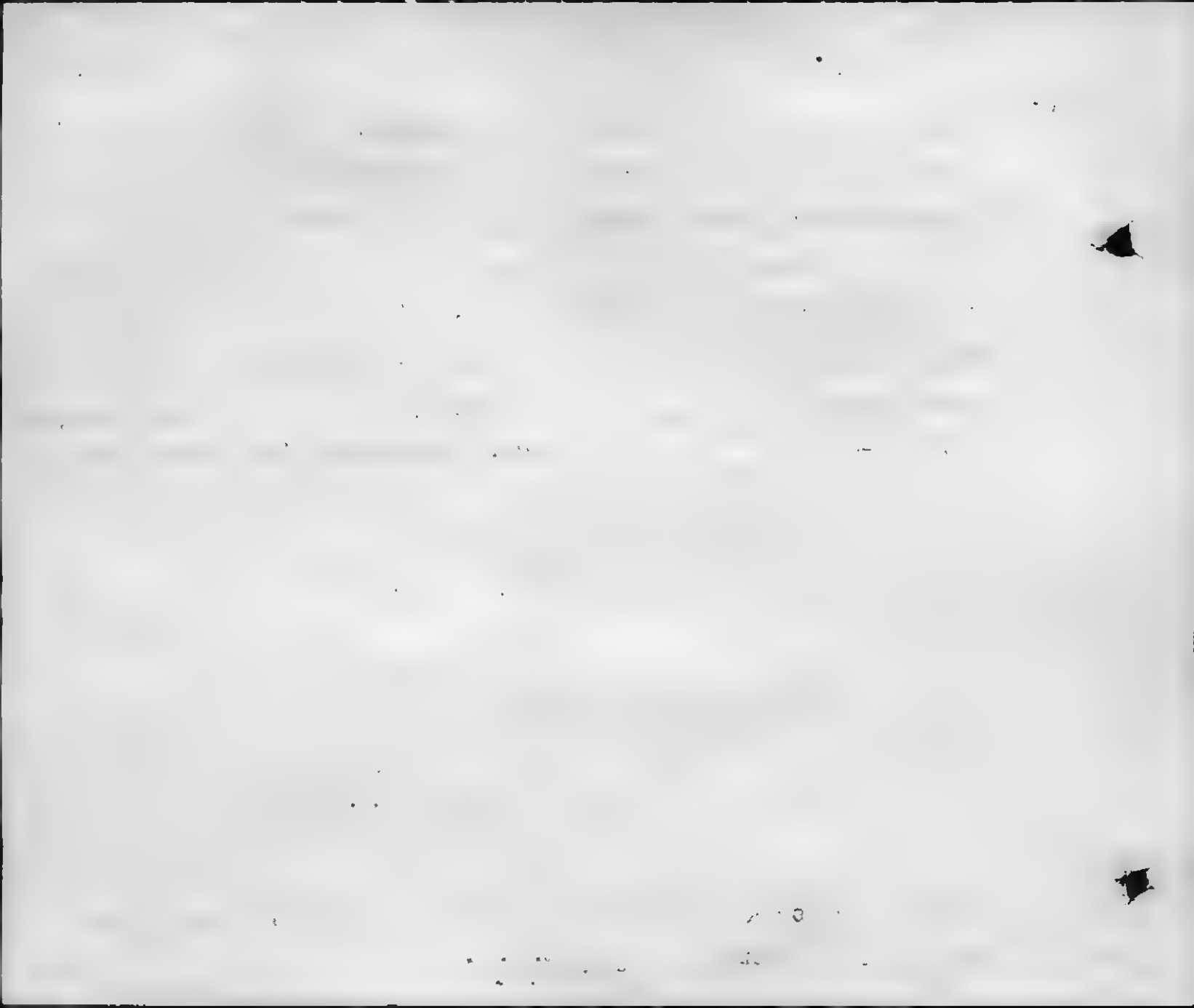
414 15th St. S. E. Washington, D. C.

25a. REC'D BY REGISTRAR

JUL 10 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Hays



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon 1 from pages 1 and 2 and file with the State Dept. of Health.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

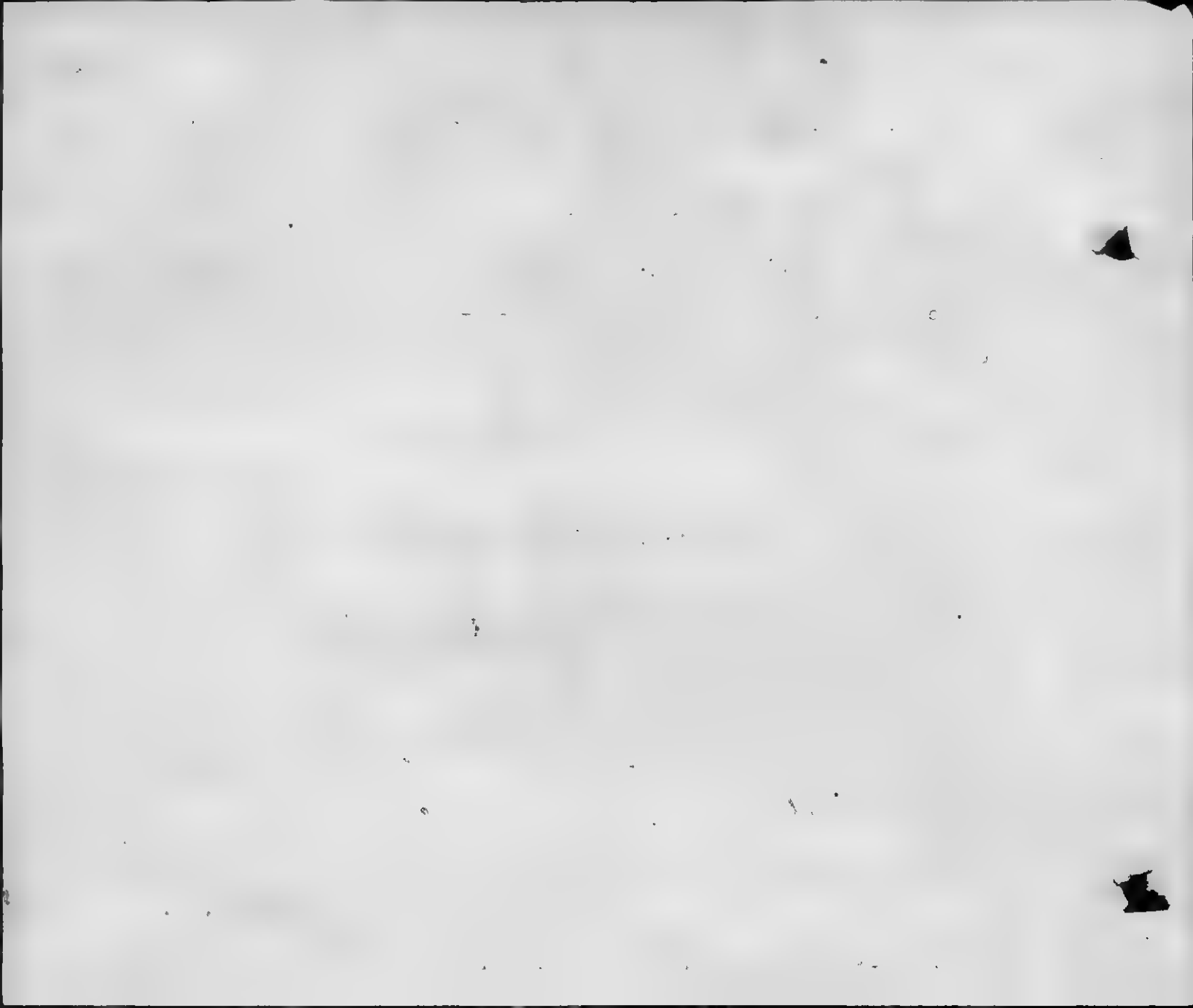
CERTIFICATE OF DEATH

8306

Item: 230, 11-11-61

08299

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> d. STREET ADDRESS <u>2 H Research Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie M. Campbell</u>		4. DATE OF DEATH <u>July 10 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-96</u>
9. AGE (In years IF UNDER 1 YEAR; IF UNDER 24 HRS. last birthday) <u>64 yrs.</u>		10. PLACE OF BIRTH (County & State or foreign country) <u>Lonaconing, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ownhome</u>	
13. FATHER'S NAME <u>David Cook</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Mc Neil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital chart</u>	
17. INFORMANT <u>Hospital chart</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cremia</u> DUE TO <u>chronic pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>Chronic pyelonephritis</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>6 years</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Obese of rt. Kidney due to surgical removal</u>	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from <u>September 18, 1960</u> to <u>July 10, 1961</u>, that (I) (we) last saw the deceased alive on <u>July 10, 1961</u>, and that death occurred at <u>7:30 PM</u>, from the causes and on the date stated above.			
28. SIGNATURE <u>Hans Wodak</u>		29. DATE <u>July 13, 1961</u>	
30. PHYSICIAN'S NAME (Type) <u>HANS WODAK</u>		31. ADDRESS <u># 9 E. Parkway Road Greenbelt, Maryland</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>July 13, 1961</u>	
34. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Burial Park</u>		35. LOCATION (City, town or county) <u>Cumberland, Md.</u>	
36. FUNERAL DIRECTOR'S SIGNATURE <u>Scarpelli Funeral Home, Maryland</u>		37. REC'D BY REGISTRAR <u>JUL 13 '61</u>	
38. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>		39. DATE <u>JUL 13 '61</u>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 83300

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3401 63rd Place	
c. LENGTH OF STAY IN b Prince George's General		d. STREET ADDRESS Cheverly Manor	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie		4. DATE OF DEATH Month 7 Day 4 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1898	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4	
11. IF UNDER 24 HRS. Hours 19 Mins. 61		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Biscar		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 579-01-9612	
17. INFORMANT Mrs. John Carpenter, 3401 63rd Place, Manor, Md.		Address Cheverly	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1961	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR F. Gasch's Sons		24a. REC'D BY REG. STRAR JUL 10 '61	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8308

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08301

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4802 - H St</u>				d. STREET ADDRESS <u>4802 - H St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Cissell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 21, 1902</u>	
9. AGE <u>59</u> years last birthday		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS Hours <u>5</u> Min <u>9</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin Cissell</u>				14. MOTHER'S MAIDEN NAME <u>Theresa City</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-09-0829</u>		17. INFORMANT <u>Mrs. H. Simpson</u> Address <u>4802 - H St, Capitol Heights</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with metastases</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/60</u> to <u>7/20</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>61</u> , and that death occurred <u>5:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William Brainin</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				22d. ADDRESS <u>612 4 Central Ave, Capitol Heights</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WW Chambers Co. 577 11th St SE Wash D.C.</u>				25a. REC'D BY REGISTRAR <u>JUL 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8303

CERTIFICATE OF DEATH

08302

Items 13 & 14 From Birth cert. 7/21/61 1wk

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Clark		4. DATE OF DEATH Month Day Year July 18 19 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 July 1961
9. AGE (In years lost birthday) yrs		10. AGE (In years lost birthday) yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Clark		14. MOTHER'S MAIDEN NAME Norma Lee Kearns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia			
7/19/61 DUE TO (b) Maternal Toxicosis of Pregnancy			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 18, 1961, to July 19, 1961, that (I) (we) last saw the deceased alive on July 18, 1961, and that death occurred at 3:23 AM. I have stated the causes and on the date stated above			
22a. SIGNATURE W H Clements M.D.			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Clements, M.D.			
22d. ADDRESS 6001-35th Ave, Hyattsville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE OF BURIAL 7/21/61			
23c. NAME OF CEMETERY OR CREMATORY Washington National			
23d. LOCATION (City, town, or county) (State) Suitland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee F. Fernal Home, Washington D.C.			
25a. REC'D BY REGISTRAR DATE JUL 21 '61			
25b. REGISTRAR'S SIGNATURE William S. Fernal			

2077252 XVL



ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8310

08303

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Montgomery ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland 12 5 2			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				d STREET ADDRESS 7212- Chestnut Street		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CECILIA Middle A. Last CLARKE				4. DATE OF DEATH Month July Day 10th Year 19 61			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 17- 1875		9 AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	IF UNDER 24 HRS. Min.
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Policewoman		11. BIRTHPLACE (State or foreign country) Washington, DC		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Fitzpatrick				14. MOTHER'S MAIDEN NAME ? Demonet			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17 INFORMANT Frank J. Clarke		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO (b) Hypertension and arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1961</u> to <u>July 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1961</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above							
22a SIGNATURE Thomas J. Kelly				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED July 10, 1961	
22c PHYSICIAN'S NAME (Type) THOMAS J. KELLY				22d ADDRESS 6480 N. H. Ave., Takoma Park, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF July 13-61		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) Washington, DC (State) _____	
24 FUNERAL DIRECTOR'S SIGNATURE Scimons Brothers				ADDRESS 1661- Good Hope Rd. SE Washington, DC		25a REC'D BY REGISTRAR DATE JUL 13 '61	
				25b REGISTRAR'S SIGNATURE Charles S. Howard			



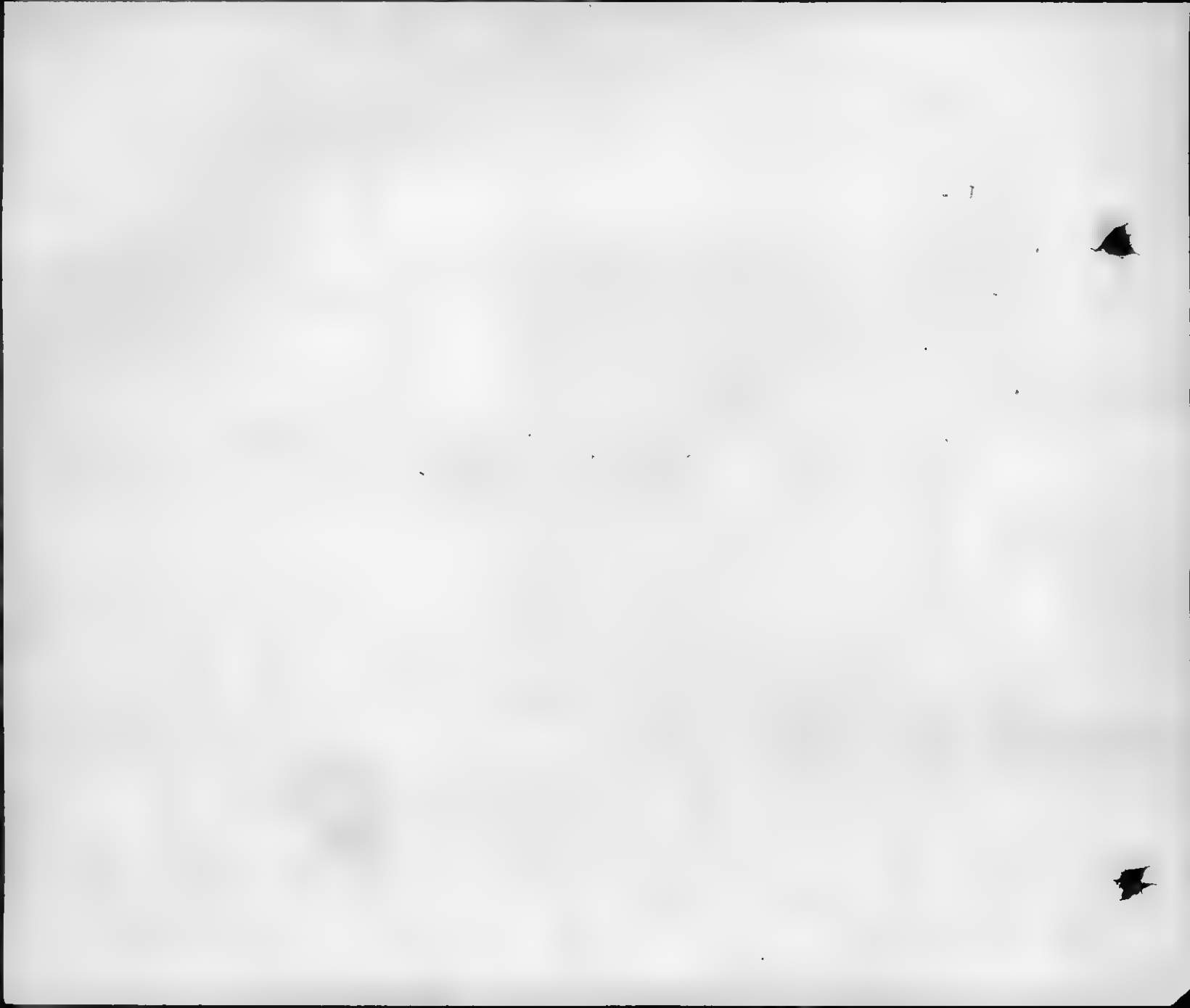
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8311

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08304

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pro George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i> <i>46</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3900 Bunker Hill Road</i>		d. STREET ADDRESS <i>3900 Bunker Hill Road</i>	
3. NAME OF DECEASED (Type or print) <i>ANNIE LUCRETIA CORNWELL</i>		4. DATE OF DEATH <i>July 21- 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUGUST 26 1868</i>
9. AGE (In years last birthday) <i>92</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME VIRGINIA</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>GEORGE POSEY</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>ESTELLE WHITE</i>		Address <i>BRENTWOOD MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive Heart Failure</i> <i>15010</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Atherosclerosis</i> DUE TO (c) <i>Serulity</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 11, 1961</i> , to <i>July 21, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 21, 1961</i> , and that death occurred <i>at 10:20 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas J. Kelly</i>		22b. DATE SIGNED <i>July 22, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas J Kelly</i>		22d. ADDRESS <i>C. 480 N. H. Ave., Takoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/25/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Manassas Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Manassas Va</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gusche Sons & Co.</i>		25. REC'D BY REGISTRAR <i>DATE JUL 26 '61</i>	
25a. ADDRESS <i>—</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



8312

CERTIFICATE OF DEATH

08306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Hospital</u>				d. STREET ADDRESS <u>7404 Landsdale St</u>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>S</u> Last <u>Person</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 6, 1921</u>	
9. AGE (In years last birthday) <u>40</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sancti Patriarco</u>				14. MOTHER'S MAIDEN NAME <u>Carmella Yasouris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Charles A De Kerario</u> Address <u>Same as</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heemorrhage and Shock</u> <u>170X</u> DUE TO <u>Carcinoma of the Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Metastatic Carcinoma of the Brain</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>61</u> , to <u>July 28</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>61</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7028 Marlboro Pkce</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Benjamin S Person</u> M.D.				PHYSICIAN'S NAME (Type) <u>BENJAMIN S PERSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-28-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland, Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B H Whittinger</u>				ADDRESS <u>1111 11th St</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



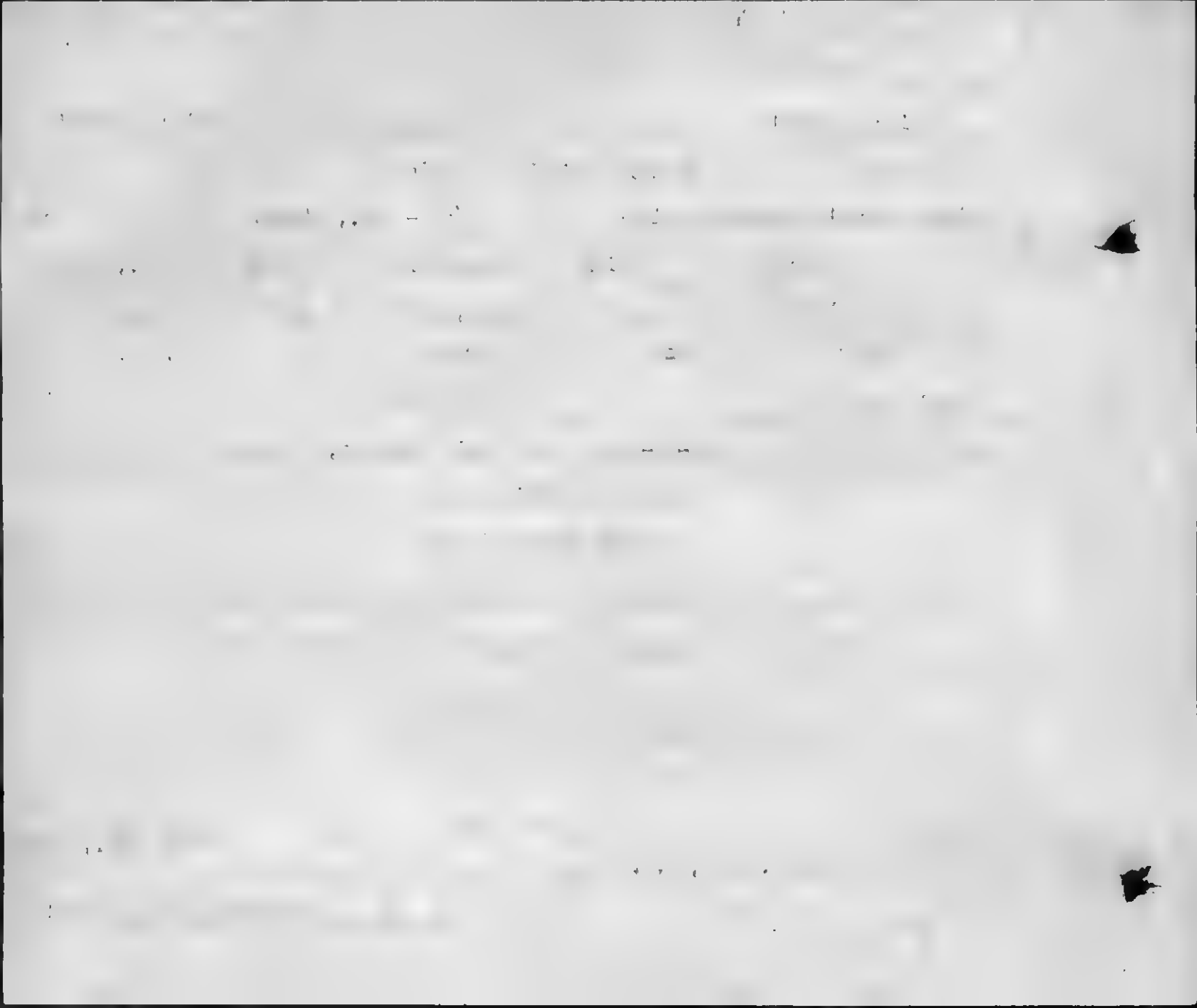
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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place to execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

8313
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03307

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived; If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>Dead on arrival</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>De Lenter</u>			d. STREET ADDRESS <u>145 - 8th. Street</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>July 5, 1919</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Gravels</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Oscar DeLenter</u>			14. MOTHER'S MAIDEN NAME <u>Hazel Rook</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-16-0937</u>		
17. INFORMANT <u>Mrs Fannie DeLenter, same as # 2</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery disease</u> (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion, death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>July 12th., 1961</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>JULY 15, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u>	
22d. LOCATION (City, town, or country) (State) <u>BLADENSBURG, MARYLAND</u>		23. FUNERAL DIRECTOR <u>W.W. Chambers Co, Riverdale, Md.</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Wm S. Kraus</u>			
DATE <u>JUL 14 '61</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after, death. Page 4 may be retained by the hospital or attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

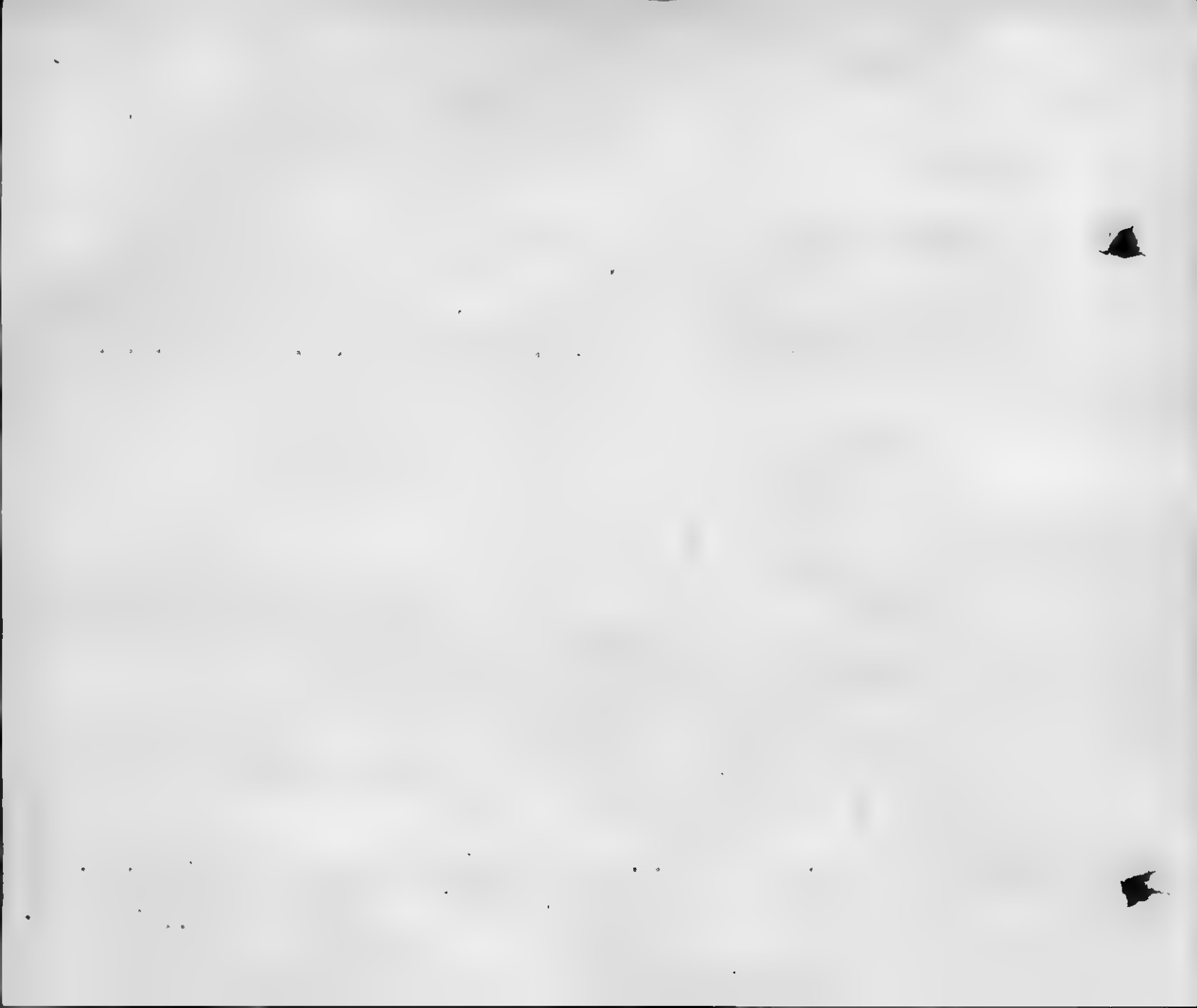
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8314

CERTIFICATE OF DEATH

08303

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>611 64th Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>James C. Dempsey</u> First Middle Last		4. DATE OF DEATH <u>July 25 1961</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>June 22, 1910</u>	
9. AGE (In years) (If under 1 year, rest birthday) Months Days Hours Min <u>51</u> yrs.		10. AGE (In years) (If under 1 year, rest birthday) Months Days Hours Min <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Librarian - Upper Marlboro, Md. Philadelphia, Pa.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia, Pa.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Viola Flaherty</u>		14. MOTHER'S MAIDEN NAME <u>Viola Flaherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>Mabel Helen Dempsey #2d above</u>	
17. INFORMANT <u>Mabel Helen Dempsey #2d above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia Right lung</u> DUE TO (b) <u>Epidemic Ear Left lung</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> to <u>7/25</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>7/25</u>, 19<u>61</u>, and that death occurred at <u>3:10</u> P.M. from the causes and on the date stated above.		22a. SIGNATURE <u>Max M. Herzberg</u> M.D. 22b. DATE SIGNED <u>7/25 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Max M. Herzberg, M.D.</u>		22d. ADDRESS <u>7016 Creig Street, Seat Pleasant, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/27/61</u>	
23c. NAME OF CEMETERY <u>Saint Dennis</u>		23d. LOCATION (City, town or county) (State) <u>Havorford Township, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan Inc. 317 Pa. Ave. S.E.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kneiss</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>		25c. DATE <u>JUL 28 '61</u>	

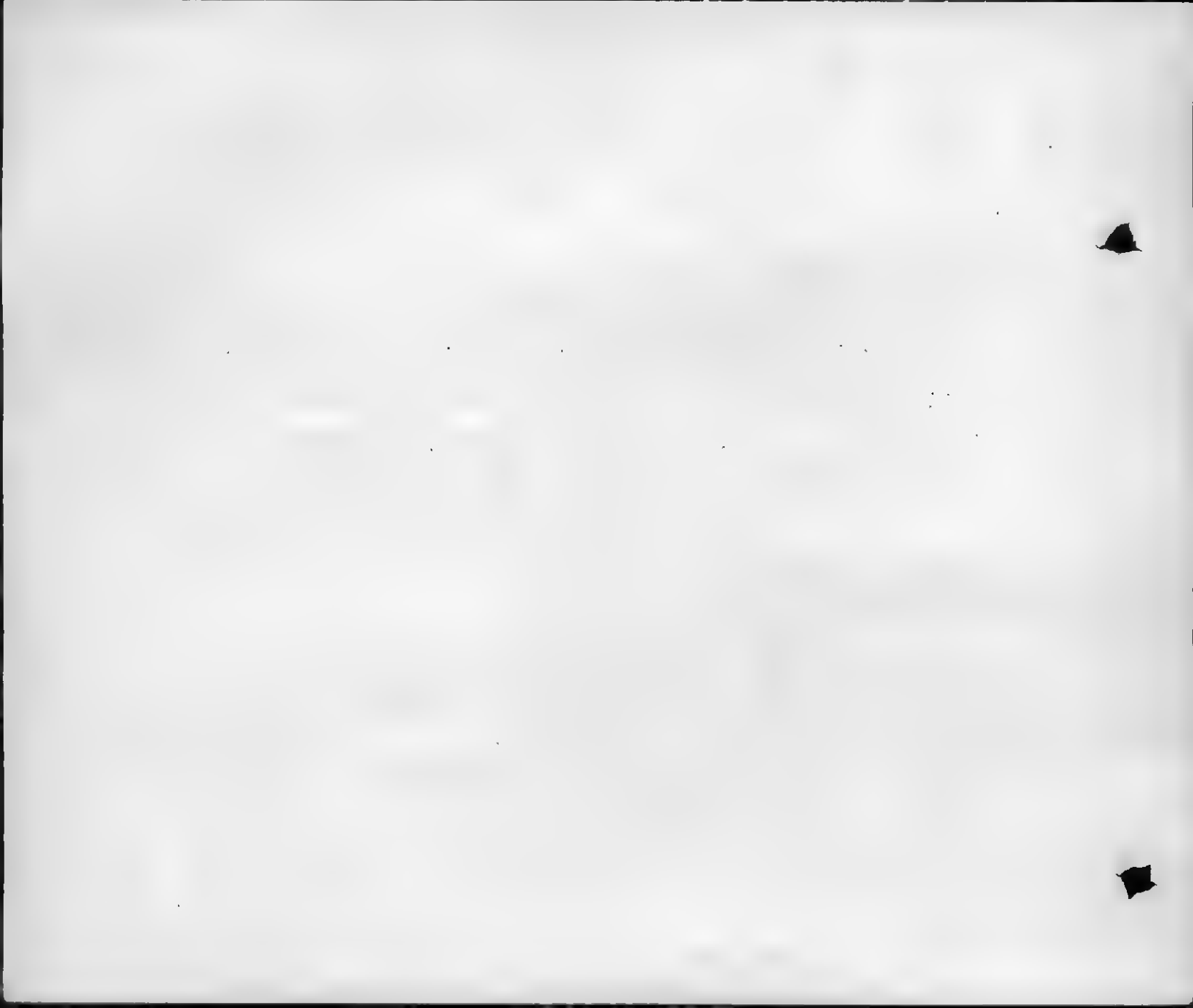


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12
8315
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08309

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE GENERAL HOSP</u>				d. STREET ADDRESS <u>9319 Jubany ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>JAMES</u> Middle <u>Dough</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-1910</u>	
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min.		IF UNDER 24 HRS. Hours <u>30</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE WAGS HEAD, N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN L. DOUGH</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE BASNIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>231-05-9488</u>			
				17. INFORMANT <u>FRANKLIN PADDY. LOTHIAN MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY THROMBOSIS, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>6 mos</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>July 19, 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1961</u> to <u>July 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1961</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Norman Donat Comeau</u> M.D.				22b. DATE SIGNED <u>7/20/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Norman Donat Comeau</u>				22d. ADDRESS <u>3503 Pennys ST MT Rainier MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-22-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>COLMAR MANOR, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier MD</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kneen</u>			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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8315

1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08310

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last David L Dowling				4. DATE OF DEATH Month Day Year July 21 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 25, 19 55	
9. AGE (In years lost birthday) 5 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME RUSSELL DOWLING				14. MOTHER'S MAIDEN NAME EVELYN DICKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO NONE		17. INFORMANT Address RUSSELL DOWLING SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 749X DUE TO Pulmonary atelectasis, bilateral Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Post-operative pneumothorax, bilateral (c) Surgery for correction of "funnel-chest"							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/1/61, 19 to 7/21/61, 19, that (I) (we) last saw the deceased alive on 6/4/61, 19, and that death occurred at 5201, from the causes and on the date stated above							
22a. SIGNATURE George William Ware M.D.				ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 22, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. George Ware, M.D.				22d. ADDRESS 1835 Eye St NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-25-1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. M. Chambers Co				ADDRESS Riverdale, Md		25a. REC'D BY REGISTRAR DATE JUL 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

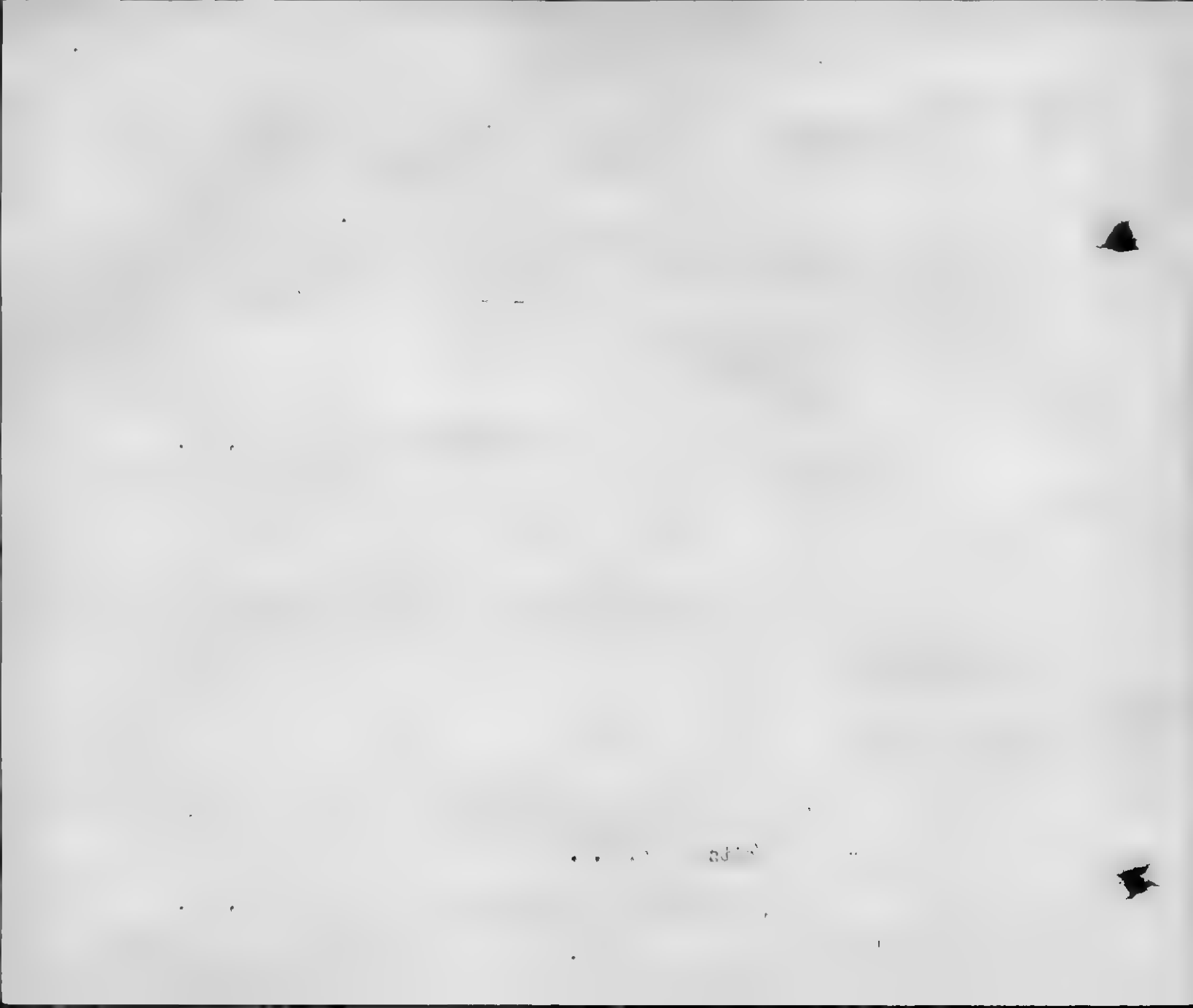


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8317
CERTIFICATE OF DEATH

08311

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN It 24 Days		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital	
2. NAME OF DECEASED (Type or print) Mamie J		3. SEX Female		4. COLOR OR RACE White		5. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
6. DATE OF BIRTH 10-27-87		7. AGE (in years, if UNDER 1 YEAR, give birthday) 73 yrs.		8. DATE OF DEATH July 9 1961		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bureau of Engraving		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH-PLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franklin Gage Tharpe Joseph Tharpe		14. MOTHER'S MAIDEN NAME Sarah Jean Baity Nesetta Albee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT John Downing, Colmar Manor, Md.		18. CAUSE OF DEATH (Enter only one cause per type for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 173.0 DUE TO Penicillin (b) Adeno ca to the ovary (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6-12-1961 to 7-9-1961, that (I) (we) last saw the deceased alive on 7-9-1961, and that death occurred at 11 A.M. from the causes and on the date stated above.		22a. SIGNATURE Dr Aaron Deitz, M.D.		22b. DATE July 9, 1961	
22c. PHYSICIAN'S NAME (Type) Dr Aaron Deitz, M.D.		22d. ADDRESS		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town or county) Bladensburg, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE William S. Kraus	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8318

08312

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>27 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clara</u> First <u>B</u> Middle <u>Drueh</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months <u>68</u>		11. IF UNDER 24 HRS Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Henry C. Luehr</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Joan L. Buffith</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>332X</u>				(b) <u>Cerebral Arteriosclerosis</u>			
(c) <u>generalized arteriosclerosis</u>				2 mos. <u>1 yr.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1960</u> to <u>July 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1961</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel J. N. Sugar</u> M.D.				22b. DATE SIGNED <u>7/30/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>				22d. ADDRESS <u>4637 EASTERN AVE., WASH DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-3-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Mem. Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Fort Wayne, Indiana</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Maryland</u>				25a. REC'D BY REGISTRAR <u>AUG 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>W. H. S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8313

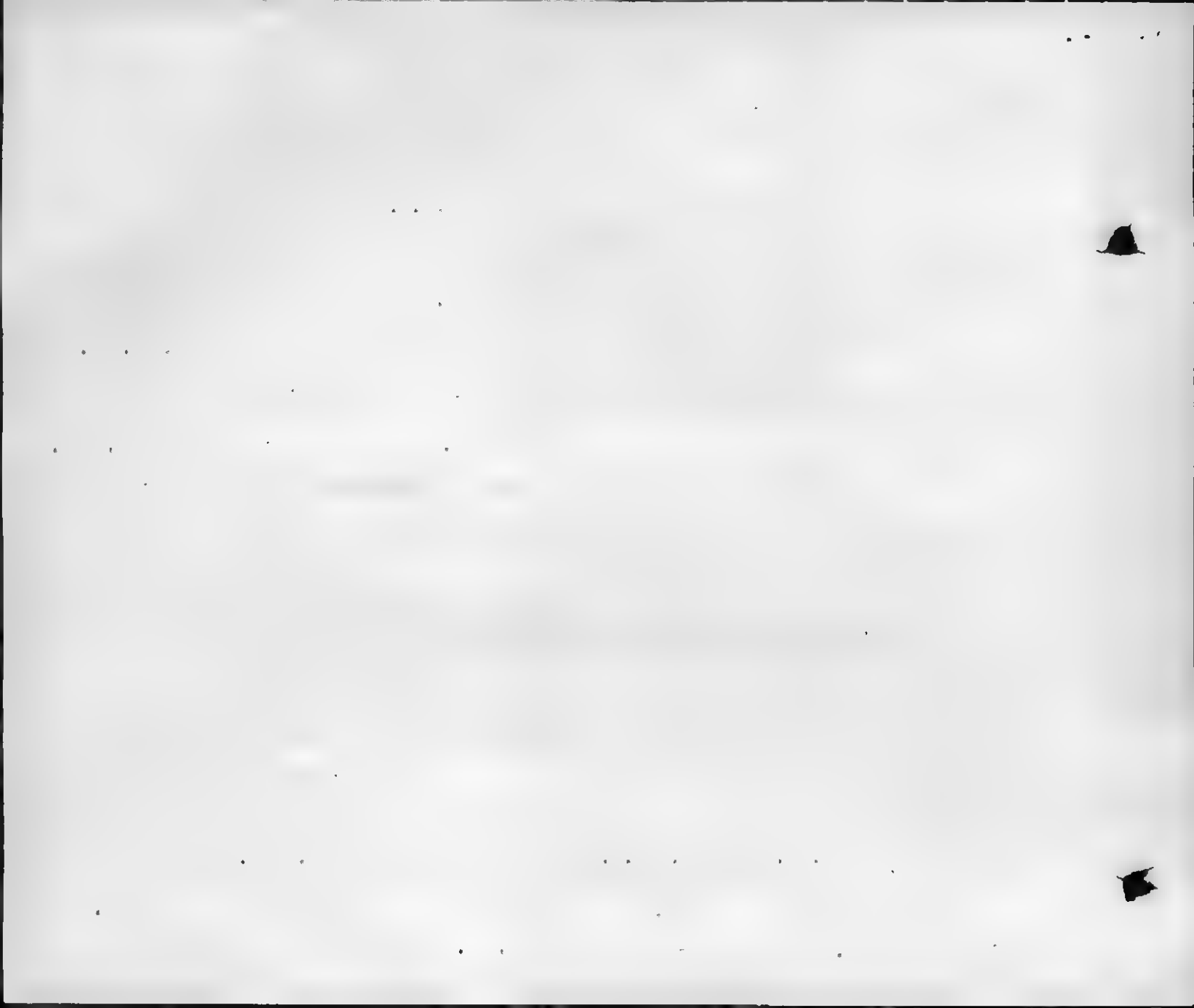
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08313

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospital				d. STREET ADDRESS R.F.D. Box 2005			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Percy Duvall				4. DATE OF DEATH Month Day Year July 29 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Nov. 1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tobacco Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Benjamin Frank Duvall				14. MOTHER'S MAIDEN NAME Elizabeth Van Ness			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -- --		17. INFORMANT Philip C. Duvall--Upper Marlboro., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO AS CVR Disease Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes gangrene - left foot				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1961 to 29 July 1961, that (I) (we) last saw the deceased alive on 28 July 1961, and that death occurred at 3:35 AM, the causes and on the date stated above.							
22a. SIGNATURE R. R. Sasscer M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/29/61	
22c. PHYSICIAN'S NAME (Type) Dr. R. Sasscer., M.D.				22d. ADDRESS Upper Marlboro., Md.			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/61		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City, town, or county) (State) Groom, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Fun'l Home-Upr Marlboro, Md.				25a. REC'D BY REGISTRAR DATE AUG 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8320

08314

1. PLACE OF DEATH
a. COUNTY **Prince Georges**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Riverdale**
c. LENGTH OF STAY IN 1b **MARYLAND**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Eugene Leland Memorial Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Howard**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Ellicott City**
d. STREET ADDRESS **Oakland Mills Road**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **INA** Middle **BERTHA** Last **ECKER**

4. DATE OF DEATH
Month **July** Day **16** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **1-30-09** 9. AGE (In years last birthday) **52** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY **Same** 11. BIRTHPLACE (County & State, or foreign country) **Tenn.** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **George Loyd Davis** 14. MOTHER'S MAIDEN NAME **Judy Ann**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **219-28-9853** 17. INFORMANT **Hospital Records** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Cerebro Vascular Accident**
DUE TO (b) **Hypertension**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **7-16**, 19**61**, to **7-16**, 19**61**, that (I) (we) last saw the deceased alive on **7-16**, 19**61**, and that death occurred at **20** pm from the causes and on the date stated above.

22a. SIGNATURE **D. R. Purdie** M.D. 22b. DATE SIGNED **7-16-61**
22c. PHYSICIAN'S NAME (Type) **D. R. Purdie, M. D.** 22d. ADDRESS **4408 Queensbury Road, Riverdale, Maryland**

23a. BURIAL, CREMATION, 23b. DATE THEREOF **Burial July 19, 1961** 23c. NAME OF CEMETERY OR CREMATORY **St Johns Cem.** 23d. LOCATION (City, town or county) (State) **Pleiffer Corner Md**

24. FUNERAL DIRECTOR'S SIGNATURE **De Witt Danielson, Laurel, Md** ADDRESS 25a. REC'D BY REGISTRAR **JUL 20 '61** 25b. REGISTRAR'S SIGNATURE **Charles E. Thomas**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. If en please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



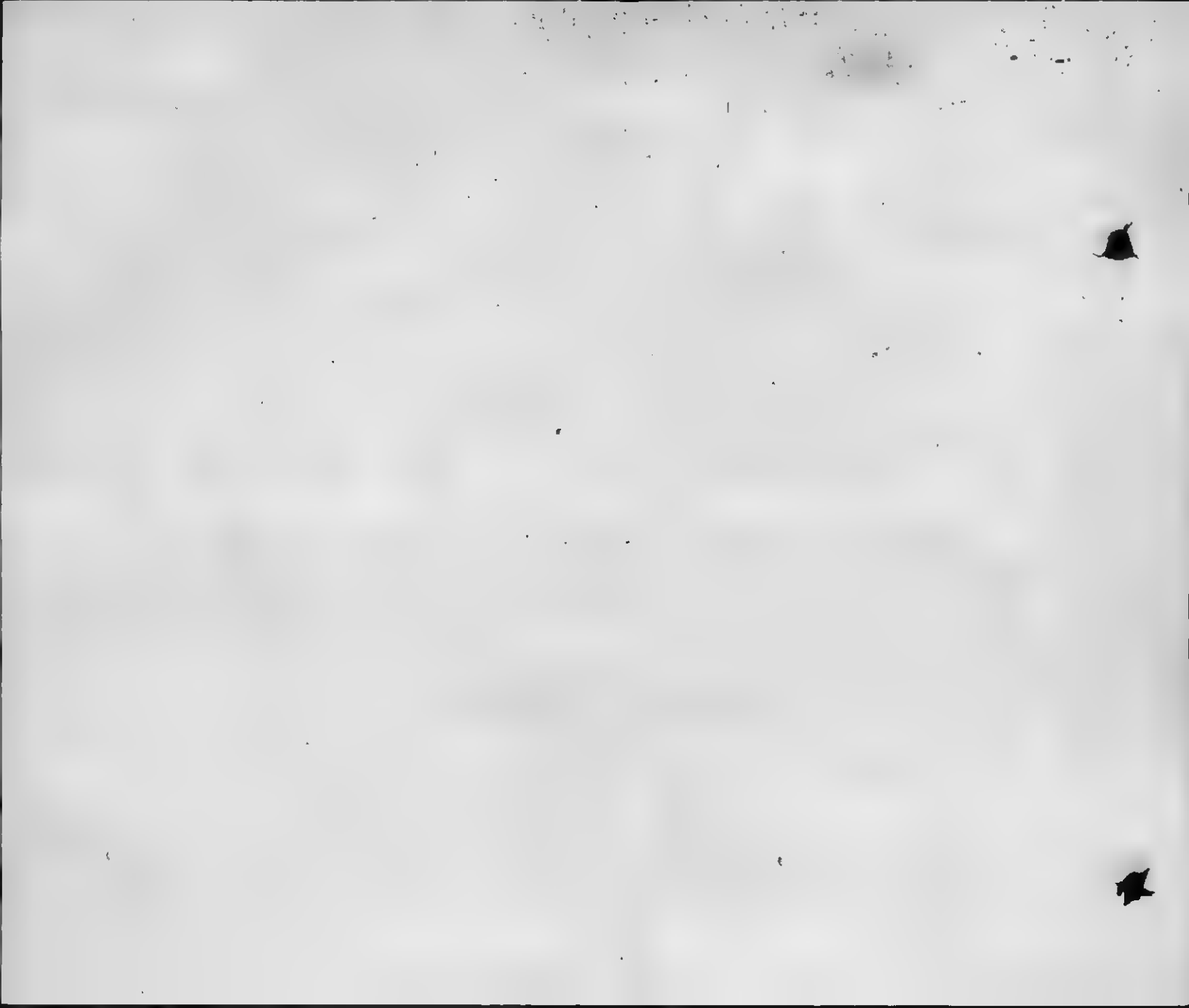
1
FOR STATE
HEALTH DEPT. (M)
X
I
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND

8321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02315

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton c. LENGTH OF STAY in b. Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Found in barn on Stoney Harbor Farm		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Farrell First Middle Last		4. DATE OF DEATH July 21 19 61 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 17, 1893 68 yrs. Month Days Years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. FARRELL		14. MOTHER'S MAIDEN NAME MARY WENK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN F. FARRELL		Address LA PLATA, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertrophy and DILATATION, HEART (c) DUE TO (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED July 21, 1961	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-24-61	
22c. NAME OF CEMETERY OR CREMATORY St Charles		22d. LOCATION (City, town, or country) (State) Indian Head, Md.	
23. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE JUL 26 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

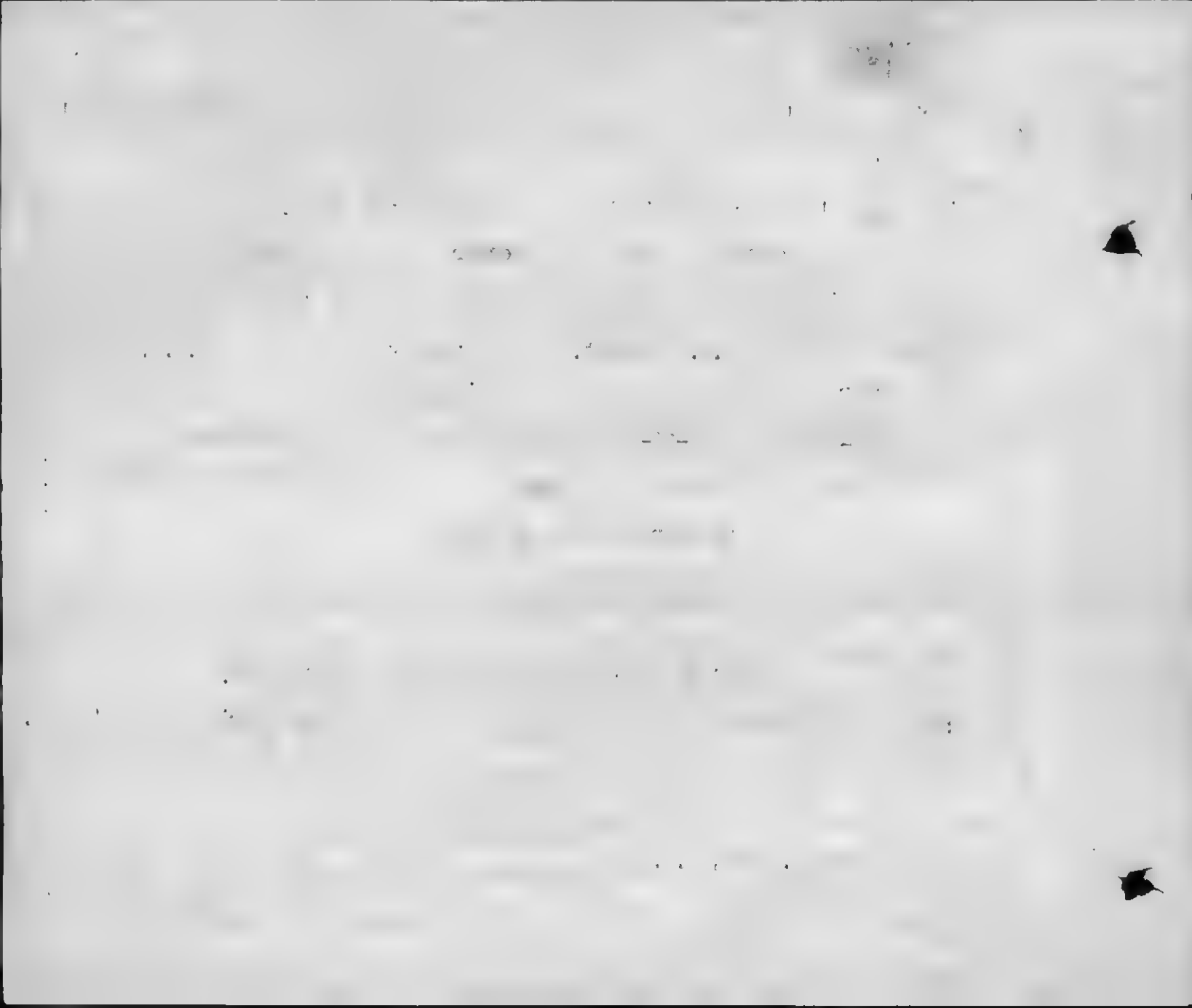


FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09316

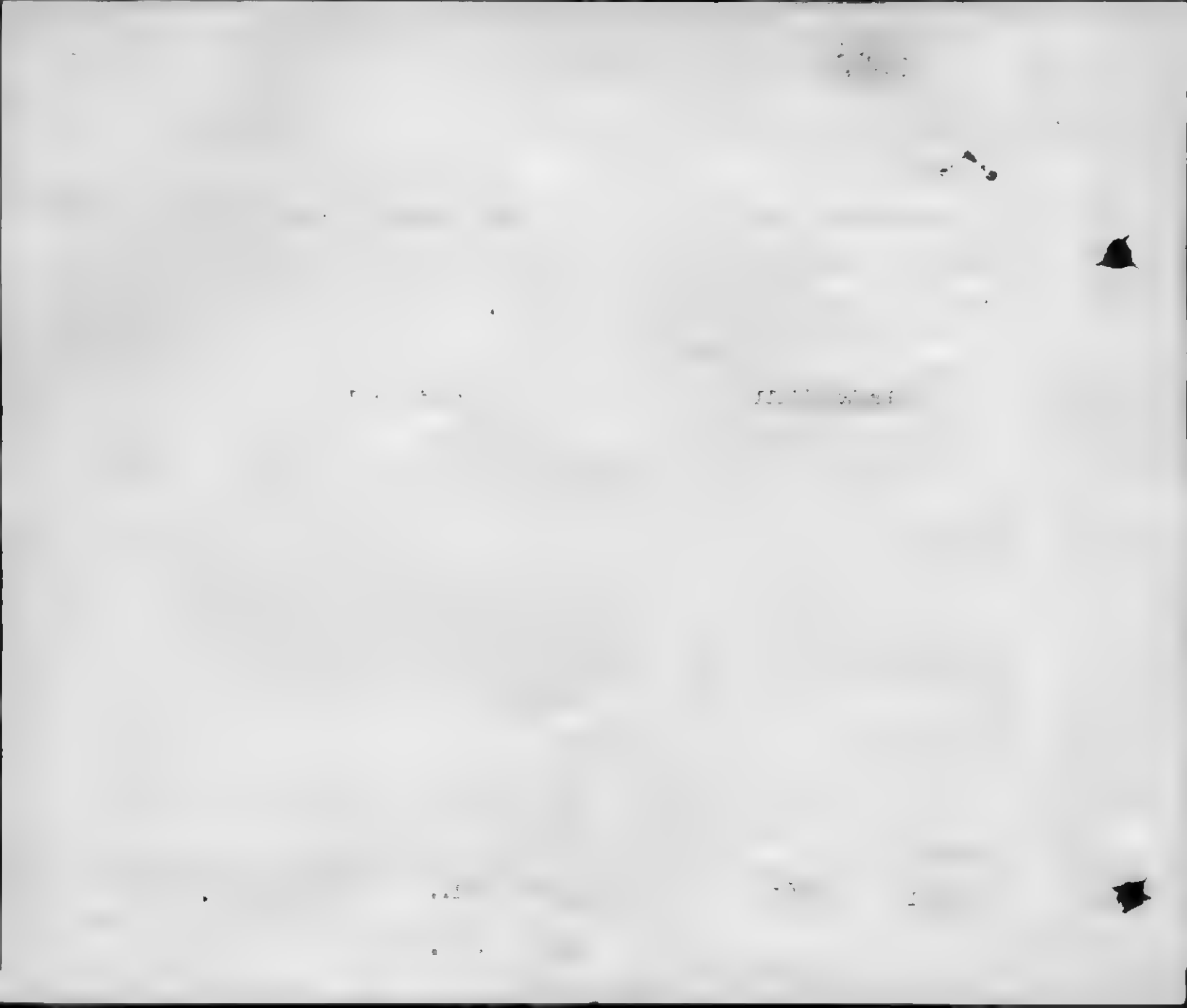
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in lb DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kentland d. STREET ADDRESS 7202 Hawthorne Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Francis Middle Earl Last Fecher		4. DATE OF DEATH Month July Day 10 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/11	9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 1 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Dept.		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Fecher		14. MOTHER'S MAIDEN NAME Lilly Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) 1935-1946		16. SOCIAL SECURITY NO. 489-32-3143		17. INFORMANT Thelma Fecher Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gun shot wound in the head DUE TO (c) Gun shot wound in the head Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went into bedroom of home and shot self in head.			
20c. TIME OF INJURY Hour 5:05 P.M. Month, Day, Year 7/10/1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Kentland	(County) Prince George's	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/10/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1961		22c. NAME OF CEMETERY OR CREMATORY Cambridge Municipal	
22d. LOCATION (City, town, or country) Cambridge, Iowa		22e. REC'D BY REGISTRAR W. W. Chambers Co. Universal, Md.		24b. REGISTRAR'S SIGNATURE Robert L. Thomas	



08312

Items 10, 11 & 12-Flt

- Journal of Management Inquiry* 18(6)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8324

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08318

1. PLACE OF DEATH a. COUNTY <u>PR. Geo.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Oxon Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6501- Circle DU.S.E.</u>				d. STREET ADDRESS <u>6501- Circle DU.S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL F FILTER</u>				4. DATE OF DEATH Month Day Year <u>July 20 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 27-1917</u>		9. AGE (In years last birthday) <u>44</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>O.M.C.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred Filter</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA BRUMMEND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>LORRAINE E. FILTER - SAME as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>AORTIC + MITRAL INSUFFICIENCY.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20</u> <u>25 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> 19 <u>61</u> , to <u>7-20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-17</u> 19 <u>61</u> , and that death occurred at <u>9</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Miguel A. Huici</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MIGUEL A. HUICI</u>				22d. ADDRESS <u>523 Y LIVINGSTON RD. S.E.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 22-61</u>		<u>Cedar Hill</u>		<u>Southland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Summons Bros</u>				ADDRESS <u>1661 9th Ave Rd S E</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

last one



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08319

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale			
c. LENGTH OF STAY IN TB DOA				d. STREET ADDRESS 5227 56th Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael		First Michael Middle Mloysius Last Foley		4. DATE OF DEATH July 13 19 61		5. AGE (in years last birthday) 65	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 25, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Patrick Foley				14. MOTHER'S MAIDEN NAME Katherine Culhane			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1				16. SOCIAL SECURITY NO. 578-14-4523			
17. INFORMANT Michael E. Foley, 8310 Stanwood Street, Carrollton, Md				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 42011 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary heart disease (c) 42011 DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER James I. Boyd NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-18-61			
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l				22d. LOCATION (City, town, or county) Arlington Na.			
23. FUNERAL DIRECTOR Donathey Idanlan Thruout Home Ave NW				24. REC'D BY REGISTRAR 3831 GA			
24b. REGISTRAR'S SIGNATURE William L. Hanna				DATE JUL 18 '61			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

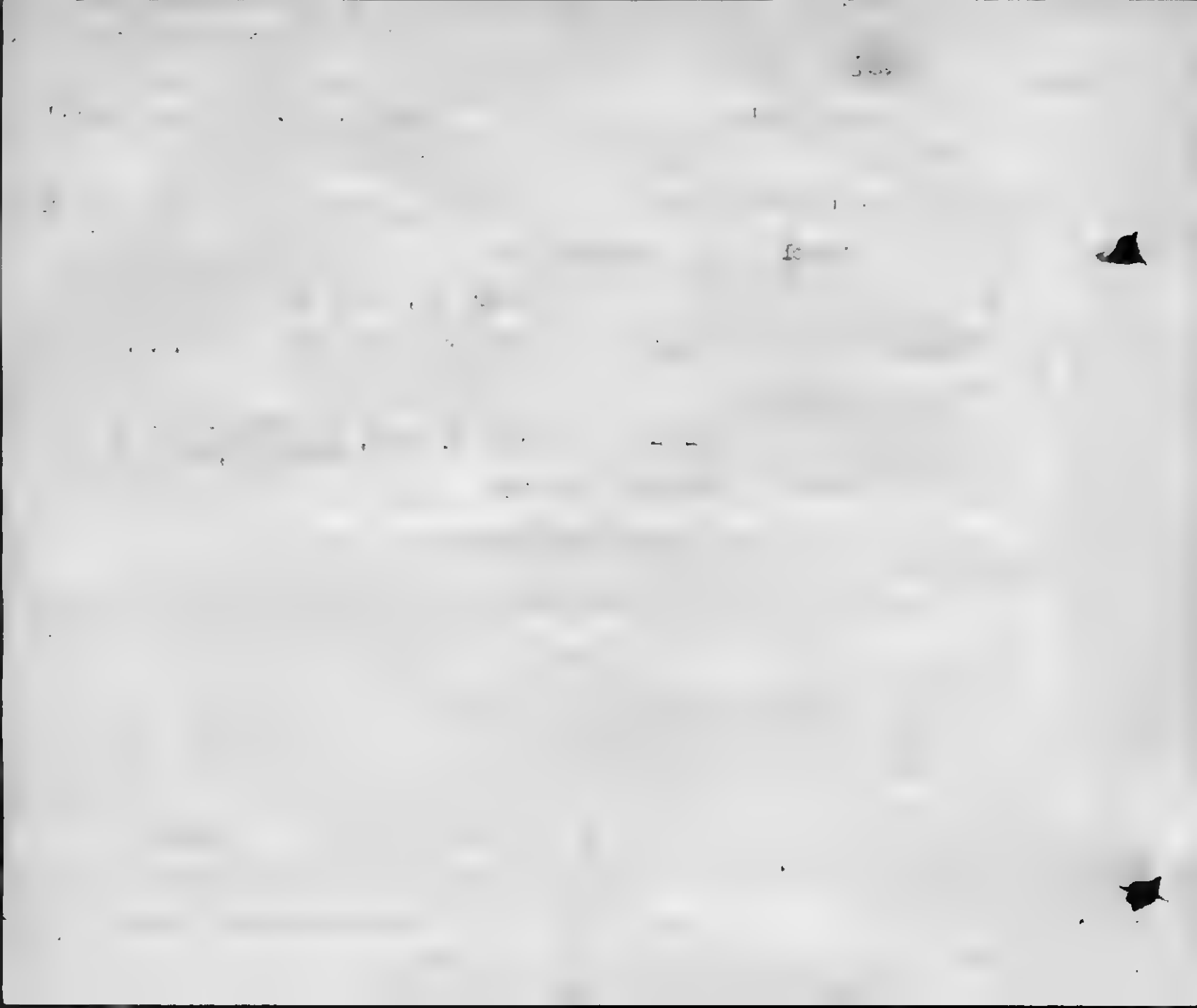
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

DATE SIGNED

7/13/61

Address (Street, city, town, or county)

DATE JUL 18 '61



FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or as soon as possible after the death, if delay is necessary, by a physician, or by a funeral director. Page 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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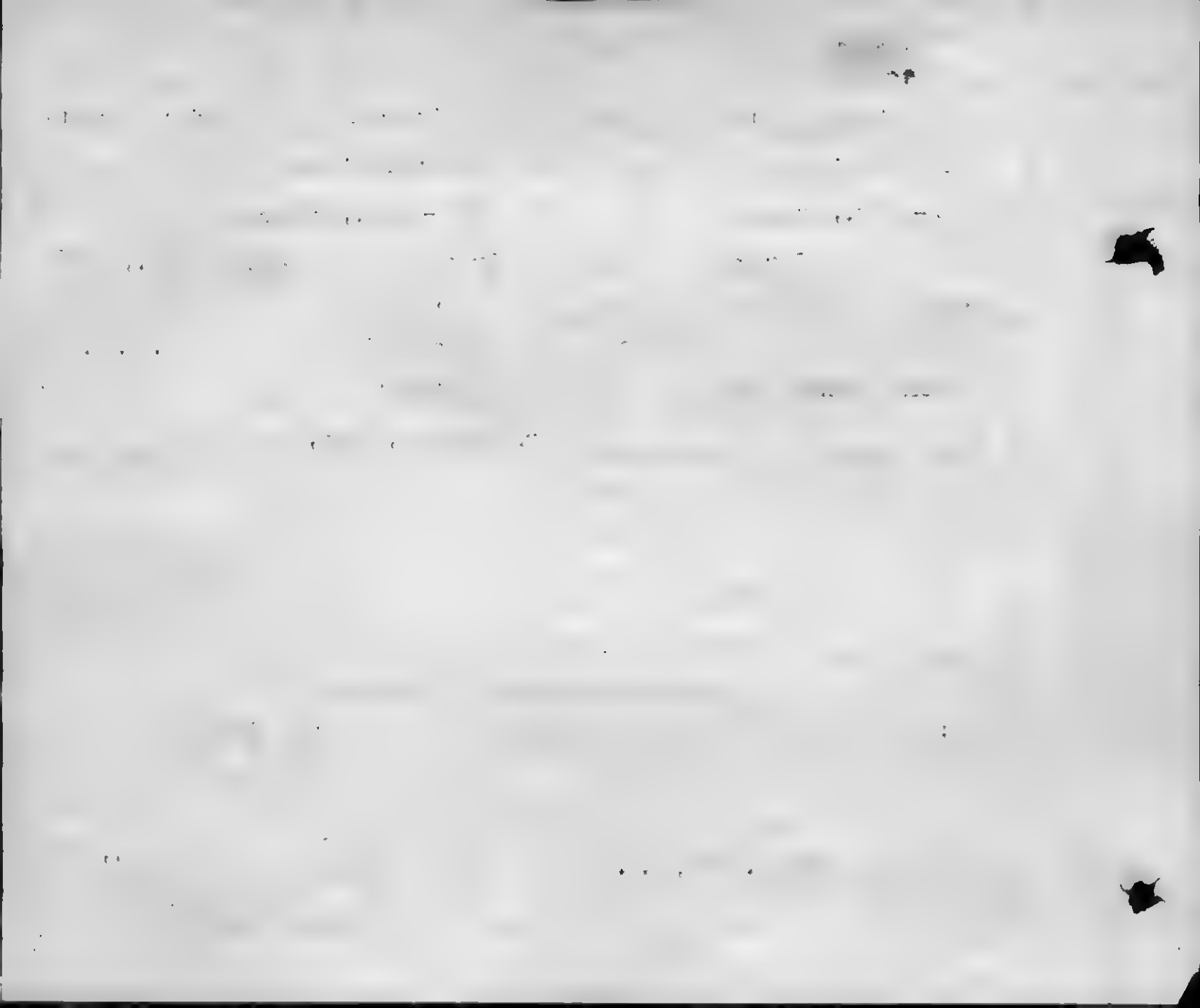
I

MEDICAL CERTIFICATION

8326 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08320

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8402 - 57th., Avenue		d. STREET ADDRESS 8402 - 57th., Avenue	
3. NAME OF DECEASED (Type or print) Bertha Mae Frey		4. DATE OF DEATH July 6th., 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME XXXXXXX Romandos Fogel		14. MOTHER'S MAIDEN NAME Emma Reichert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Kenneth H. Frey, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO HANGING Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) HANGING (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self from door in bed room	
20c. TIME OF INJURY Month, Day, Year 4:30 AM 7/6/1961		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20e. CITY OR TOWN Berwyn Heights		20f. STATE Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 10, 1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or country) Coopersburg, Penna.	
23. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md		24a. REC'D BY REGISTRAR JUL 12 61	
24b. REGISTRAR'S SIGNATURE Carlton E. Hays		DATE July 6th., 1961	



TO FURNISH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

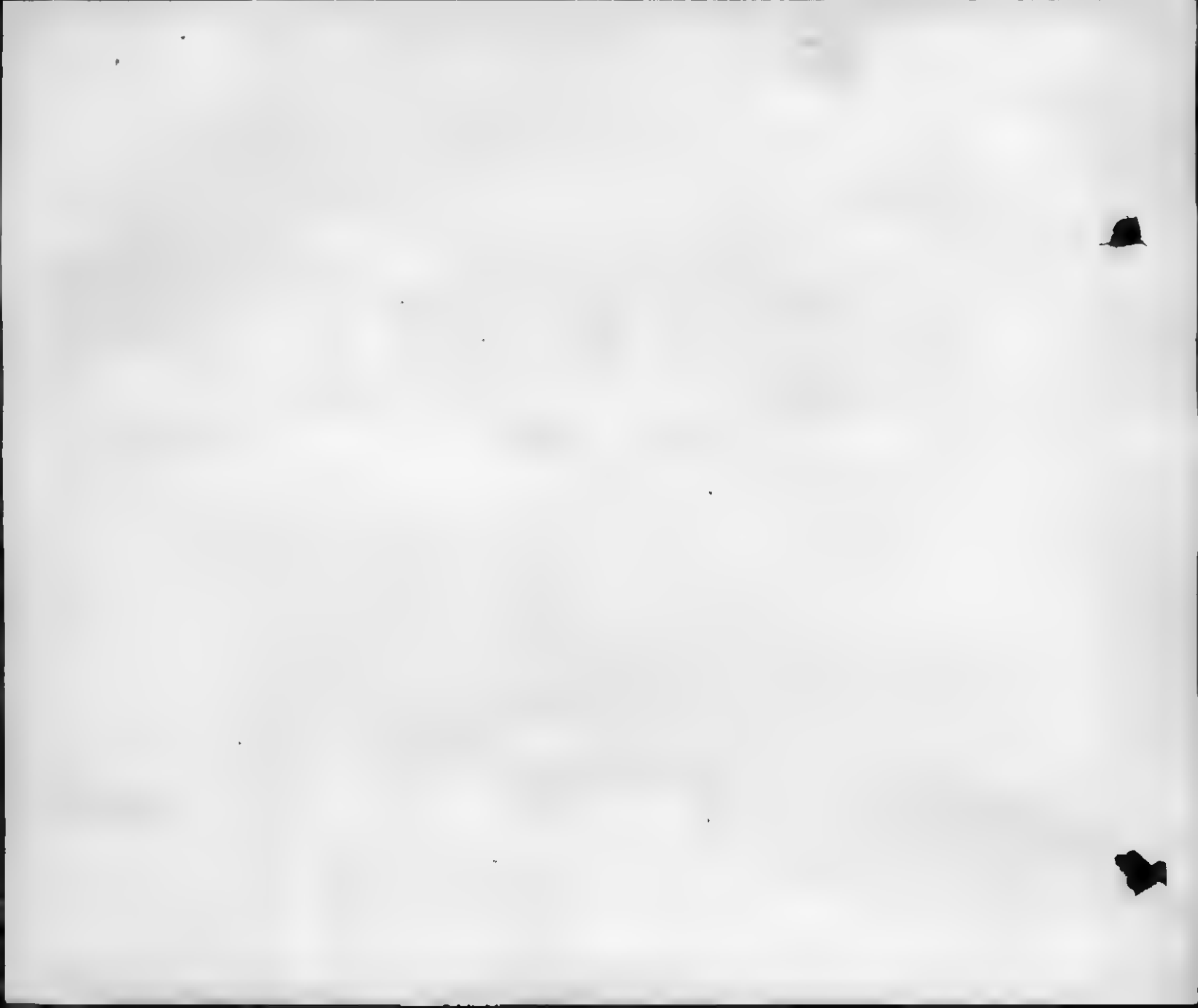
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15M 9/59

8327

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08321

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, MD		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 4775 HURON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First STEPHEN Middle GERMANA Last GERMANA		4. DATE OF DEATH Month JULY Day 3 Year 19 61	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 OCTOBER 1959
9 AGE (In years last birthday) 1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME RICHARD W GERMANA		14. MOTHER'S MAIDEN NAME ELENA M CUCCURULLO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16 SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction DUE TO Tumor of Mediastinum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tumor of Mediastinum DUE TO (c) Tumor of Mediastinum			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (1) this hospital attended the deceased from 30 June 1961 to 3 July 1961 , that (1) the last saw the deceased alive on 3 July 1961 , and that death occurred at 11:55 AM from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Cox, Col. USAF MC		22b. DATE SIGNED 3 July 61	
22c. PHYSICIAN'S NAME (Type) PHILIP A COX, Colonel USAF MC		22d. ADDRESS USAF HOSP, ANDREWS AFB, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6 JULY 1961	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City, town, or county) (State) ARLINGTON VA.
24. FUNERAL DIRECTOR'S SIGNATURE Cuadri Funeral Home, Inc. 816 H St. NE		25a. REC'D BY REGISTRAR JUL 6 '61	
ADDRESS 22		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

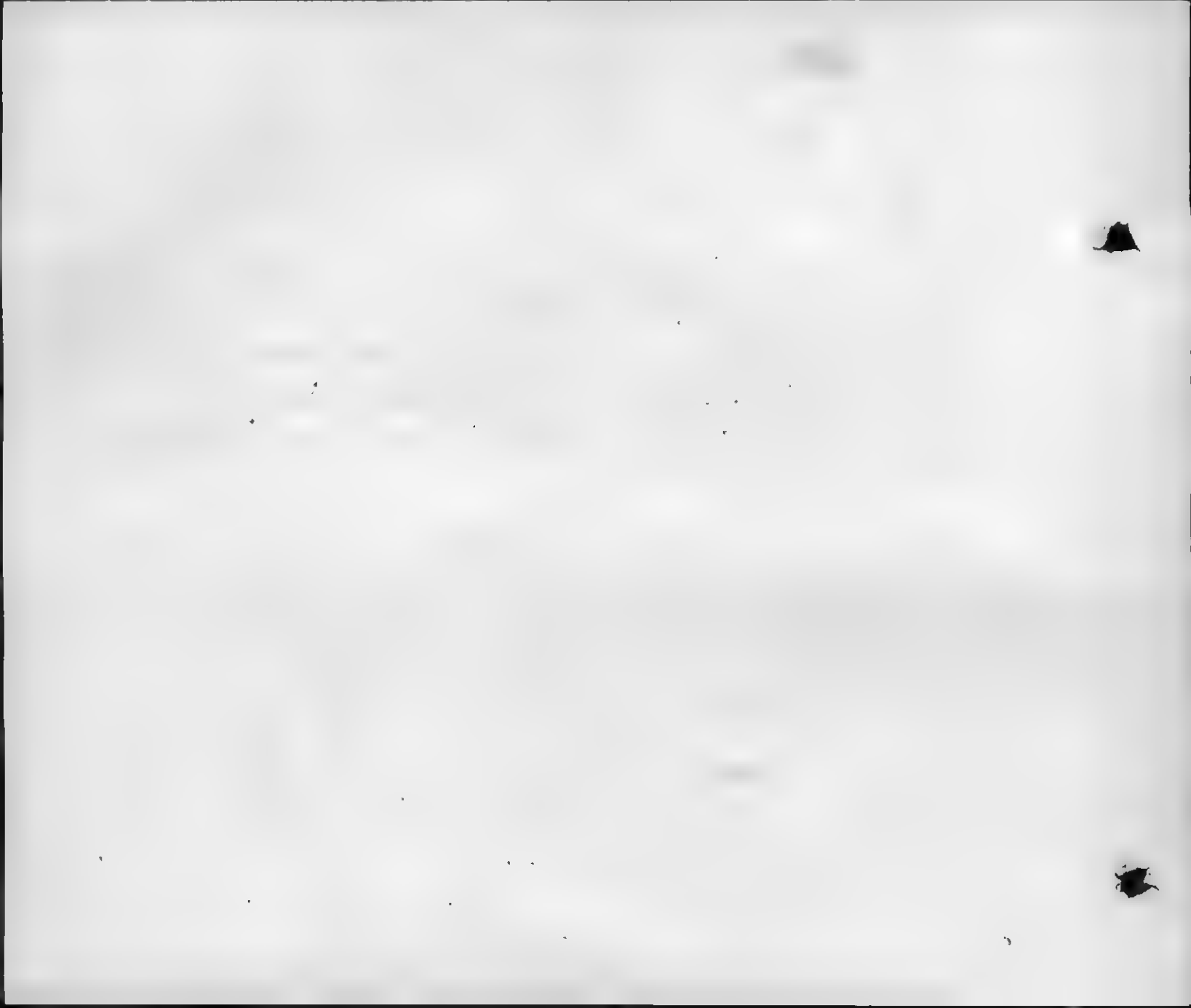
8328

CERTIFICATE OF DEATH

08322

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 4804 Craig Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marshall Middle WAYLAND Last Gilbert				4. DATE OF DEATH Month July Day 31 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 30, 1885	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 5 Hours 15 Min 00		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 00		12. CITIZEN OF WHAT COUNTRY? U. S. A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor, Retired				10b. KIND OF BUSINESS OR INDUSTRY 11. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME JAMES M. GILBERT				14. MOTHER'S MAIDEN NAME HENRIETTA ROWLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 246-07-5887		17. INFORMANT ALICE SCHIATTAREGGIA Address RESIDENTIAL GARDENS ALEX. VA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL ASTHMA INTERVAL BETWEEN ONSET AND DEATH 2 DAYS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 7/30, 1961 to 7/31, 1961 , that (I) (we) last saw the deceased alive on 7/31, 1961 , and that death occurred at 8:07 M. from the causes and on the date stated above.			
22a. SIGNATURE C. James Duke				22b. DATE SIGNED 8/1/61		22c. PHYSICIAN'S NAME (Type) C. James Duke, M.D.	
22d. ADDRESS 6607 Riverdale Road, Riverdale, Md.				23a. REC'D BY REGISTRAR W. Chambers Co. Riverdale, Maryland			
23b. REGISTRAR'S SIGNATURE W. Chambers Co. Riverdale, Maryland				23c. NAME OF CEMETERY OR CREMATORY BLADENSBURG, MARYLAND			
23d. LOCATION (City, town or county) (State)				23e. DATE AUG 4 '61			

MEDICAL CERTIFICATION

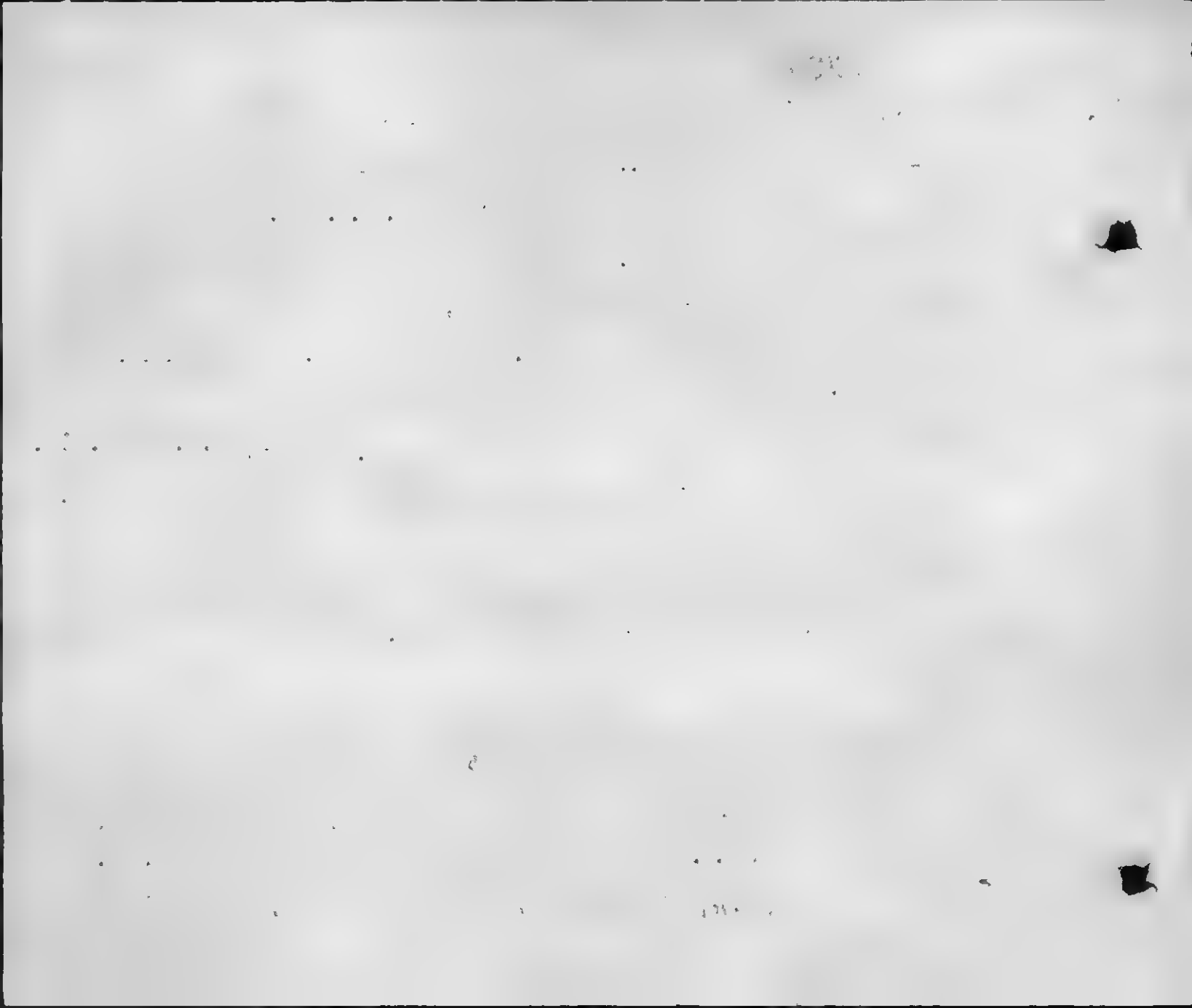


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8329 CERTIFICATE OF DEATH 08323														
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Glenn Dale c. LENGTH OF STAY IN 1b 1 mo., 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1701 16th St., N.W. Apt. 554 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Mildred S. Goodman					4. DATE OF DEATH July 1 1961									
5. SEX Female 6. COLOR OR RACE white					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 17, 1897									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant					10b. KIND OF BUSINESS OR INDUSTRY General Service Adm.					11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.				
13. FATHER'S NAME William J. Miller					14. MOTHER'S MAIDEN NAME Martha Holland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT (Person) Edna M. Murray, Address 1701 16th St. N.W. Wash. D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas with metastases to liver 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 mo				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecysto-enterostomy and gastro-jejunosotomy, June, 1960										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from May 26 1961 to July 1 1961 that (I) (we) last saw the deceased alive on July 1 1961 and that death occurred at 10:05 PM from the causes and on the date stated above.										22a. SIGNATURE Moe Weiss M.D. 22b. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.				
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.					22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					22e. DATE SIGNED July 1, 1961				
23a. BURIAL, CREMATION, REMOVAL (Specify) July 5, 1961					23b. DATE THEREOF July 5, 1961					23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery				
23d. LOCATION (City, town or county) Fort Myers, Va					23e. (State) Va									
24. FUNERAL DIRECTOR'S SIGNATURE Joseph P. ...					25a. REC'D BY REGISTRAR JUL 5 '61					25b. REGISTRAR'S SIGNATURE Arthur S. ...				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

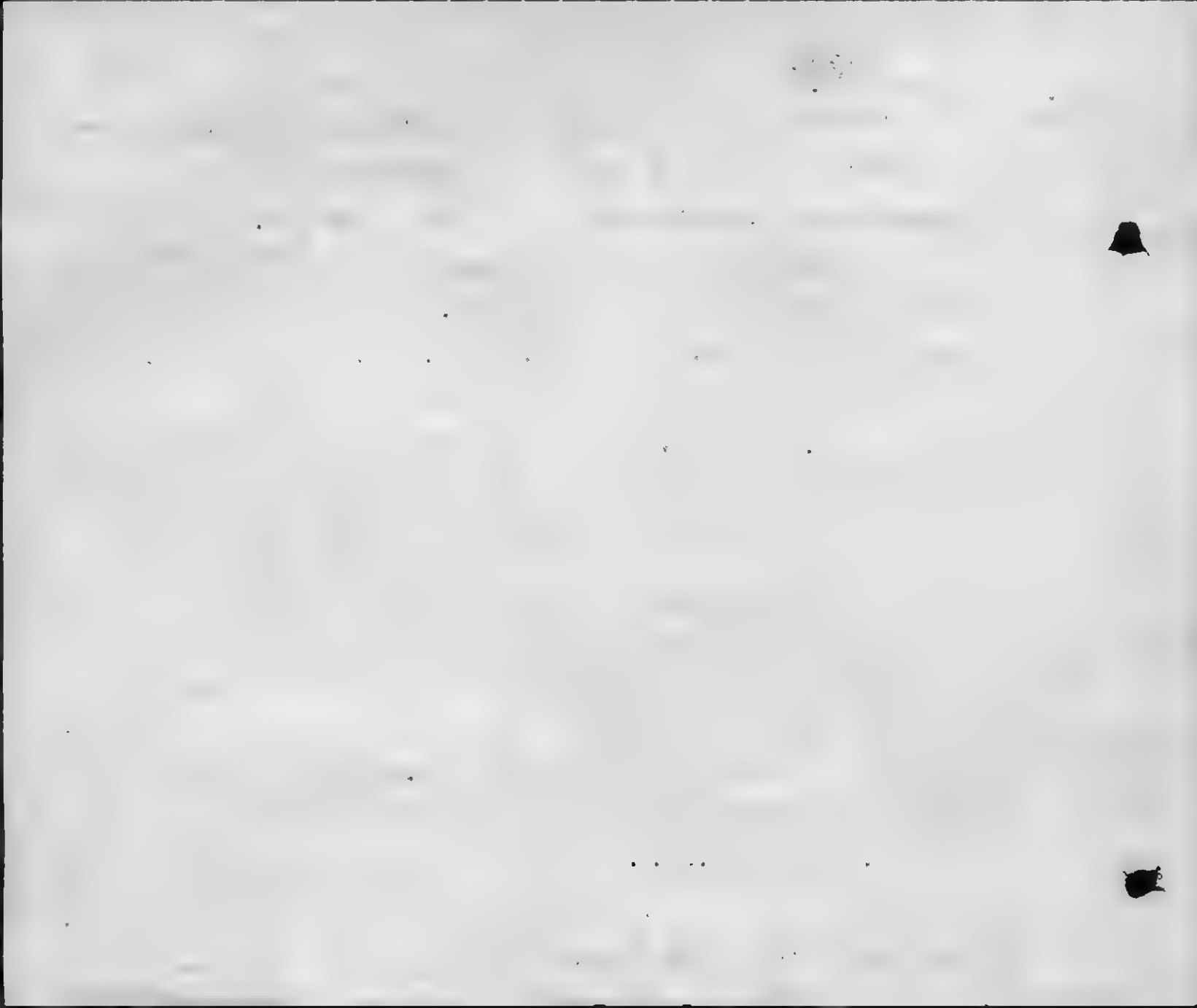
8330

CERTIFICATE OF DEATH

08324

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN TB <u>26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> d. STREET ADDRESS <u>8816 62nd Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Male</u> <u>White</u> <u>Bernard C Goodwin</u>		4. DATE OF DEATH <u>July 12 11 19 61</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 Aug. 1911</u>		9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR: Months <u>12</u> Days <u>11</u> Hours <u>11</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Service Ad.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Laura Mills</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>CS W.W.II</u> 16. SOCIAL SECURITY NO. <u>573-12-4137</u> 17. INFORMANT <u>Hospital Records</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>HYPERTENSIVE RENAL NEPHROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., _____)												INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u> <u>10 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>July 10 1961</u> Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____															
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1961</u> to <u>July 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 10, 1961</u> and that death occurred <u>July 11, 1961</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Dr. Albert Roth</u>						22b. DATE SIGNED <u>July 10 1961</u>			22c. PHYSICIAN'S NAME (Type) <u>Dr. Albert Roth, M.D.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>A.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hanson F.H.</u>						25a. REC'D BY REGISTRAR <u>July 18 1961</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pines</u>						



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

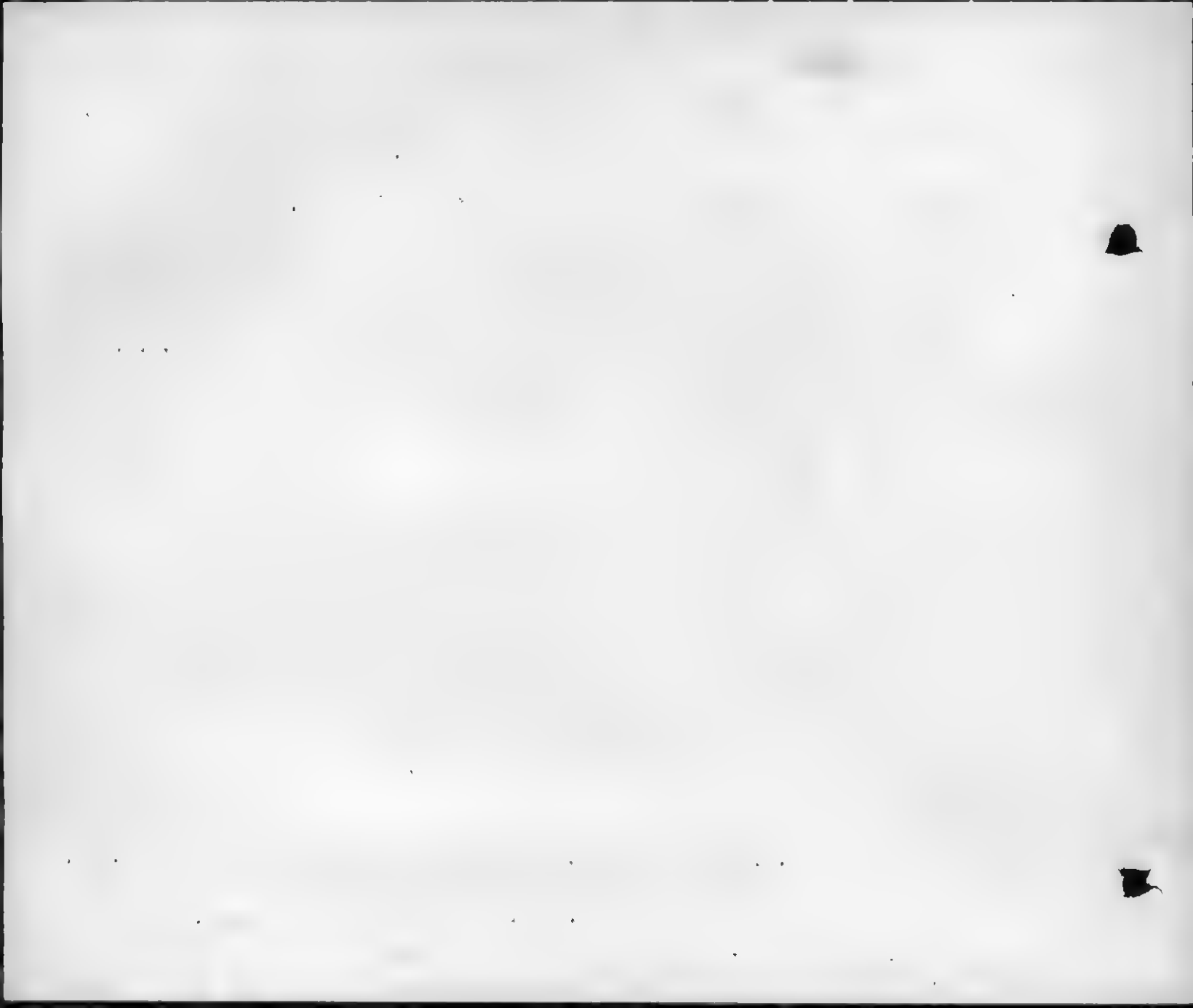
8331

CERTIFICATE OF DEATH

08325

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill			
f. STREET ADDRESS 8921 Old Fort Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Gordon				4. DATE OF DEATH Month Day Year July 14 19 61			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 July 1961	
9. AGE (in years last birthday) yrs. 14		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (in years last birthday) yrs. 14		IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Jackson				14. MOTHER'S MAIDEN NAME Grace Gordon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot 75410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH from birth from birth							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 7:05 AM, from the causes and on the date stated above.							
22a. SIGNATURE Thomas A. Christensen M.D.				22b. DATE SIGNED 7/15/61			
22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D.				22d. ADDRESS 6905 Baltimore Ave., College Park, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town, or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUL 24 '61			

Harry W. Penn, Jr., Administrator



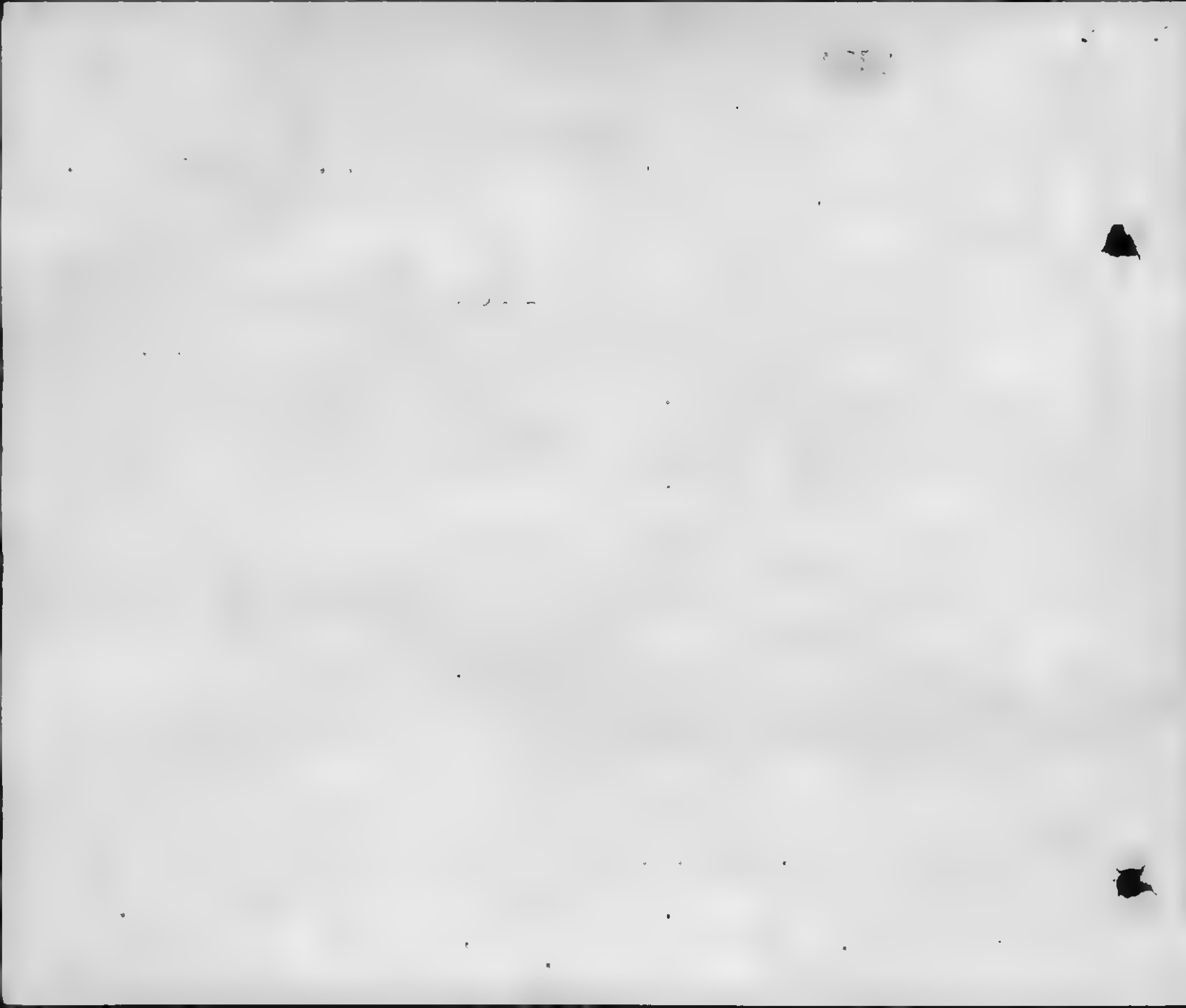
1
FOR STATE
HEALTH DEPT.

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
08326									
1. PLACE OF DEATH a. COUNTY Prince George's					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN 1b DOA				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Luther Hedrick Griffin					d. STREET ADDRESS Desmond Walker's Farm				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					8. DATE OF BIRTH -2-20-55 2/26/55				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY None				
13. FATHER'S NAME Luther Hedrick Griffin, Jr.					14. MOTHER'S MAIDEN NAME Rose Lee Delharte				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No					17. INFORMANT Luther Hedrick Griffin Jr Same address as #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 129.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Drowning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off of pier into pond.					INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 7/7/61					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm					20f. (City or town) (County) (State) Woodmore Prince George's Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
REPORT SIGNATURE EXAMINER'S NAME (Type) James I. Boyd, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7/11/61				
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery					22d. LOCATION (City, town, or county) (State) Bladensburg Md.				
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro, Md.					24a. REC'D BY REGISTRAR JUL 14 '61				
					24b. REGISTRAR'S SIGNATURE Arthur L. Thomas				

VS. A15ME
5M 7/59

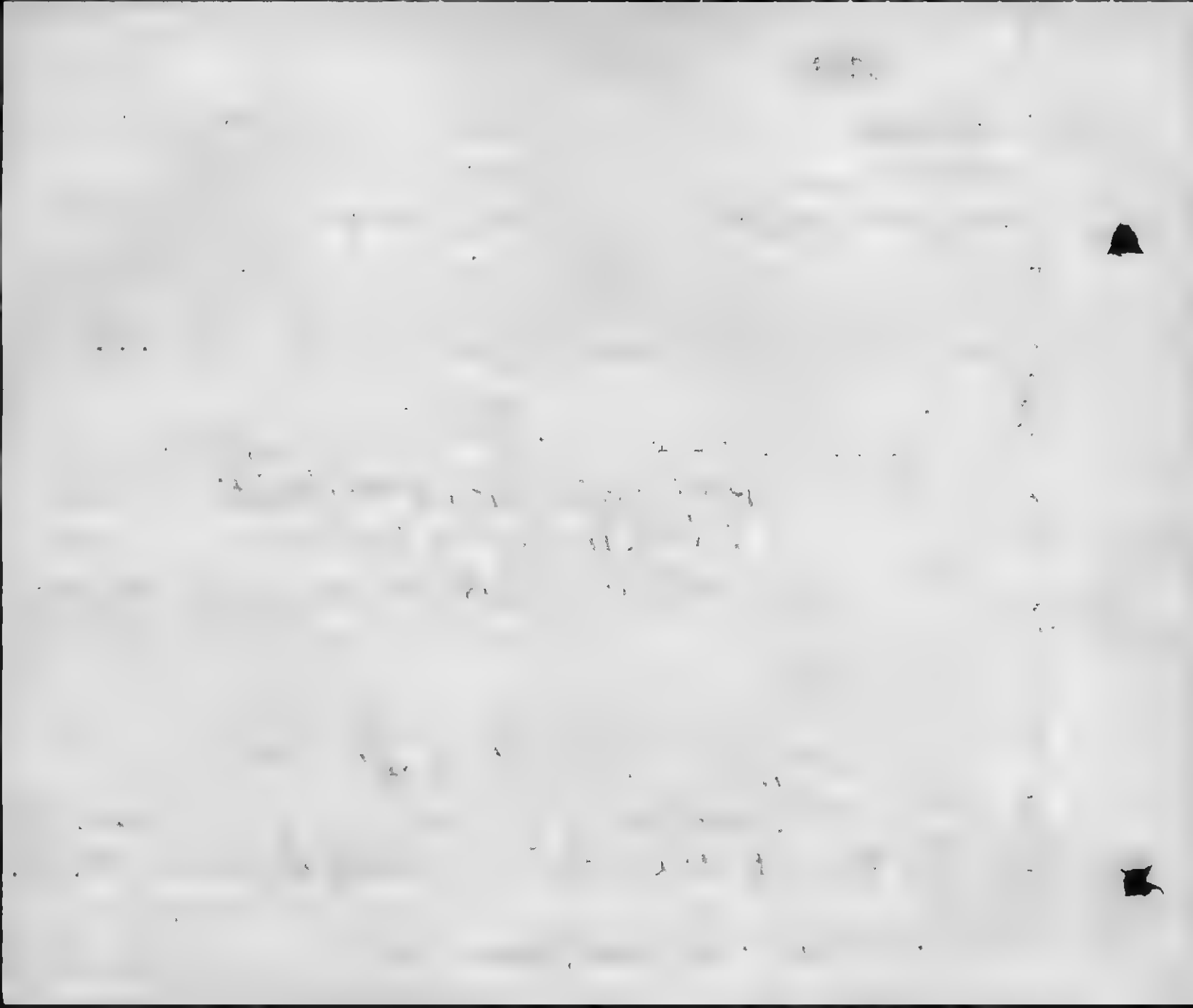


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coroner Notified And Approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8333											
08327											
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 6209 Beale Circle				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grace Opal Hall				4. DATE OF DEATH July 25 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographic Oil Artist				10b. KIND OF BUSINESS OR INDUSTRY Self employed				11. BIRTHPLACE (County & State, or foreign country) Cherryville, Kansas			
13. FATHER'S NAME James C. Imel				14. MOTHER'S M.A.DEN NAME Sarah Warren				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 579-14-1575				17. INFORMANT Mr. Howard Ralph Hall 6209 Beale Circle Riverdale, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO				Perforation Colon & Peritonitis Intestinal Obstruction Carcinoma, Rectum				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 wk. 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 19				20g. (County) 19				20h. (State) 19			
21. I certify that (I) (the hospital) attended the deceased from 7/24 , 19 61 , to 7/25 , 19 61 , that (I) (we) last saw the deceased alive on 7/25 , 19 61 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Wm. A. Holbrook				22b. DATE SIGNED 7/25/61							
22c. PHYSICIAN'S NAME (Type) Wm. A. Holbrook				22d. ADDRESS 4500 College Ave., College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/28/61				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
23d. LOCATION (City, town or county) Montgomery County, Maryland				23e. (State) 19							
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, Inc.				24a. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland				25a. REC'D BY REGISTRAR JUL 28 '61			
24b. DATE Raymond & Ziska				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3334

00323

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Box 1004		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Hamilton				4. DATE OF DEATH Month July Day 1 Year 1961			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 June 1961	
9. AGE (In years last birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Charles H				14. MOTHER'S MAIDEN NAME Heleh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Intra cranial Damage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-29-1961 to 7-1-1961 that (I) (we) last saw the deceased alive on 7-1-1961 , and that death occurred at 3:45 AM , from the causes and on the date stated above							
22a. SIGNATURE John W. Perkins				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John Perkins				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City, town, or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George W. Penn, Jr., Administrator				25a. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

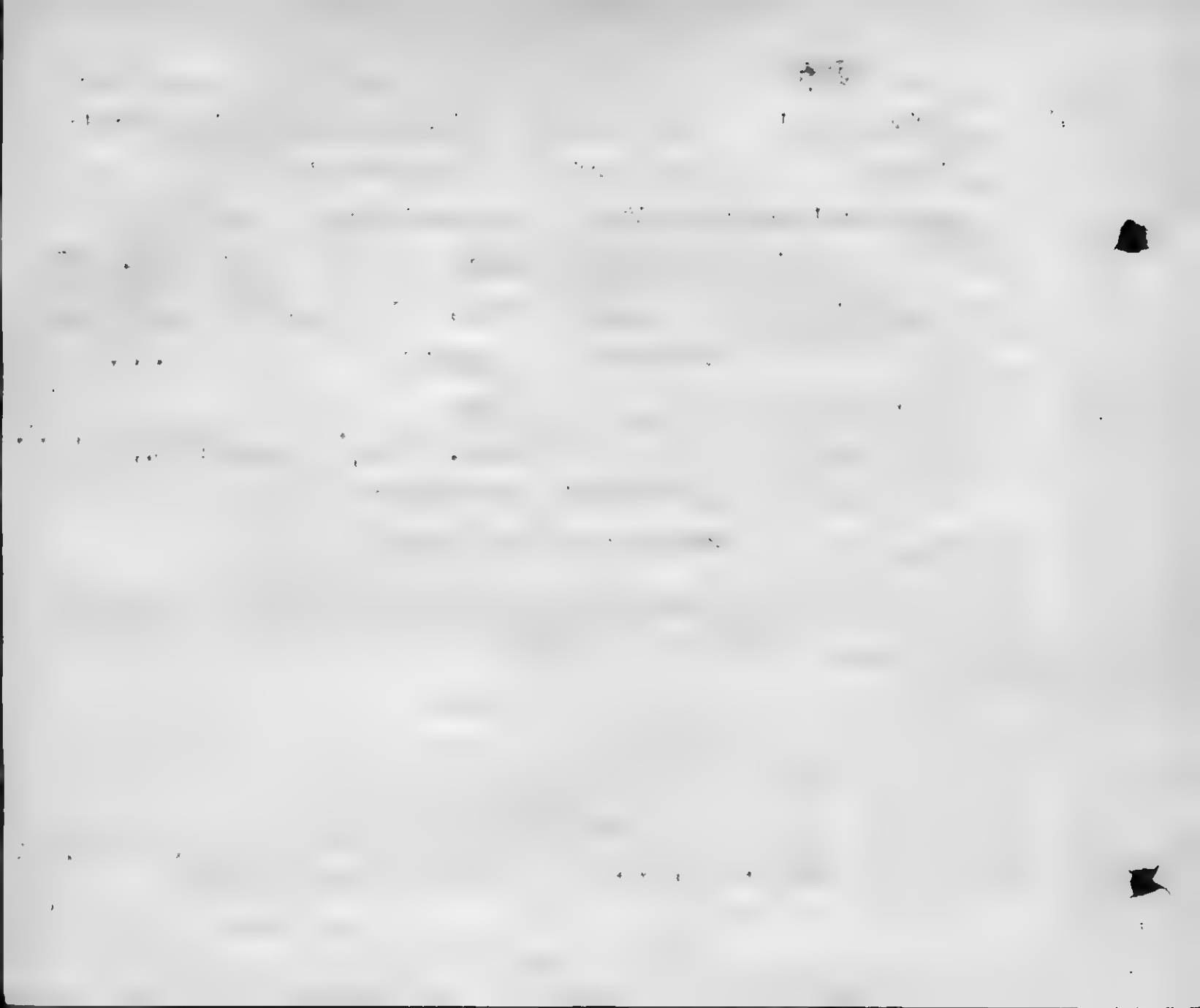
VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
10. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		13. SOCIAL SECURITY NO.	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		15. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
16. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		17. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
18. TIME OF INJURY		19. INJURY OCCURRED	
20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21. (City or town)	
22. (County)		23. (State)	
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		25. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
26. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		27. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
28. DATE SIGNED		29. July 11th. 1961	
30. ADDRESS (Street, city, town, or county)		31. 22a. LOCATION (City, town, or country)	
32. 22b. DATE THEREOF		33. 22c. NAME OF CEMETERY OR CREMATORY	
34. 22d. BURIAL, CREMATION, or REMOVAL (Specify)		35. 22e. REC'D BY REGISTRAR	
36. 22f. FUNERAL DIRECTOR		37. 22g. REGISTRAR'S SIGNATURE	
38. 22h. ADDRESS		39. 22i. DATE JUL 13 '61	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

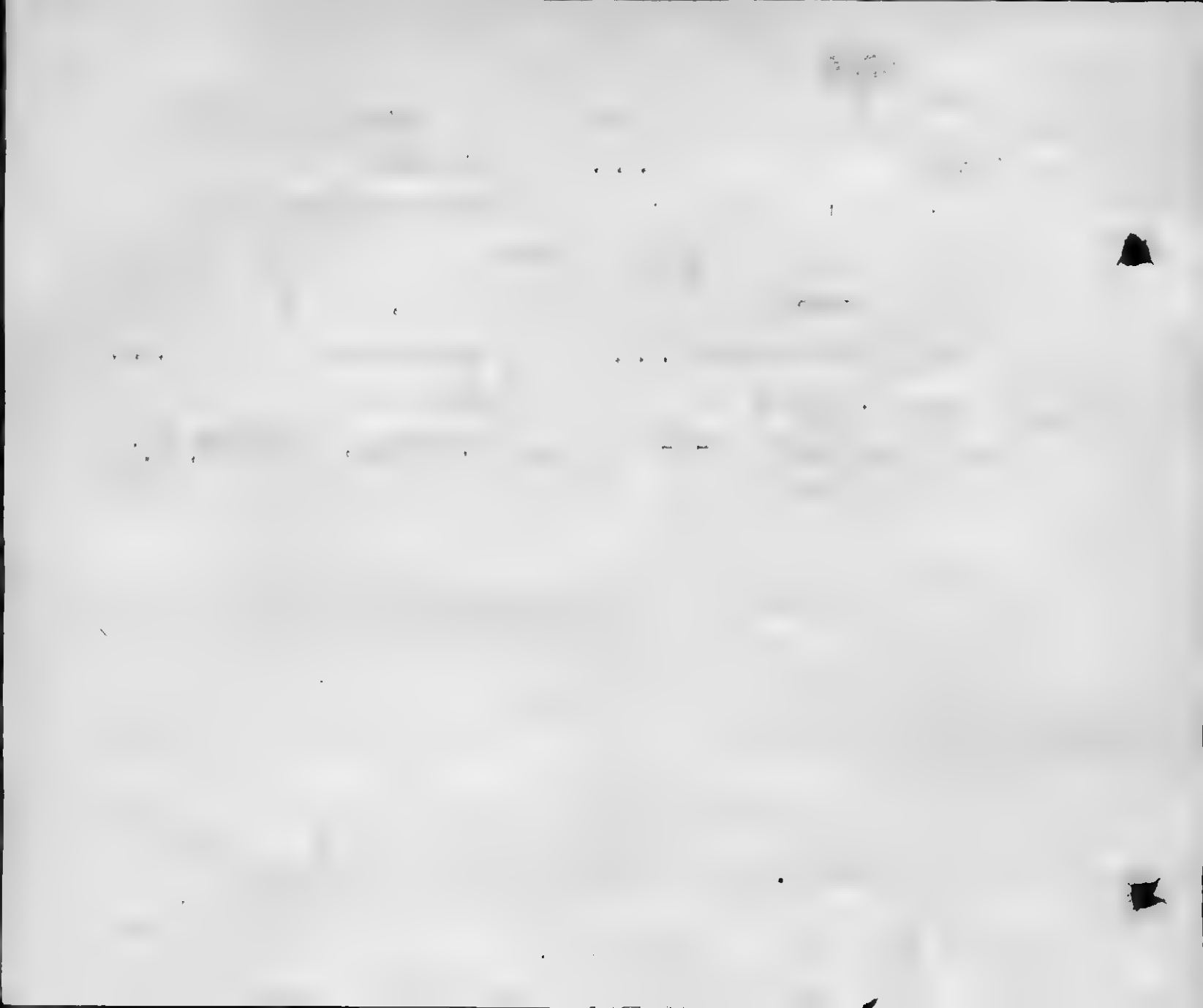
08330

FOR STATE
HEALTH DEPT.

Delay is necessary. General Director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 5017 Tuckerman Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George Middle Eugene Last Harbaugh	4. DATE OF DEATH	Month July Day 16 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1915
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Superintendent P.E.P.Co	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest A. Harbaugh		14. MOTHER'S MAIDEN NAME Evelyn Starnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 578-09-1973	
17. INFORMANT James A. Harbaugh		Address 5006 Olympia Ave, Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA and extensive body burns 7/16/61 DUE TO (b) FIRE Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in burning car 20c. TIME OF INJURY Month, Day, Year 11-12 July 15 1961 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Along highway GREENBELT PR GEO Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED 7/16/61	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1961	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or country) (State) Silver Springs, Md	
23. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR Jul 19 1961		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

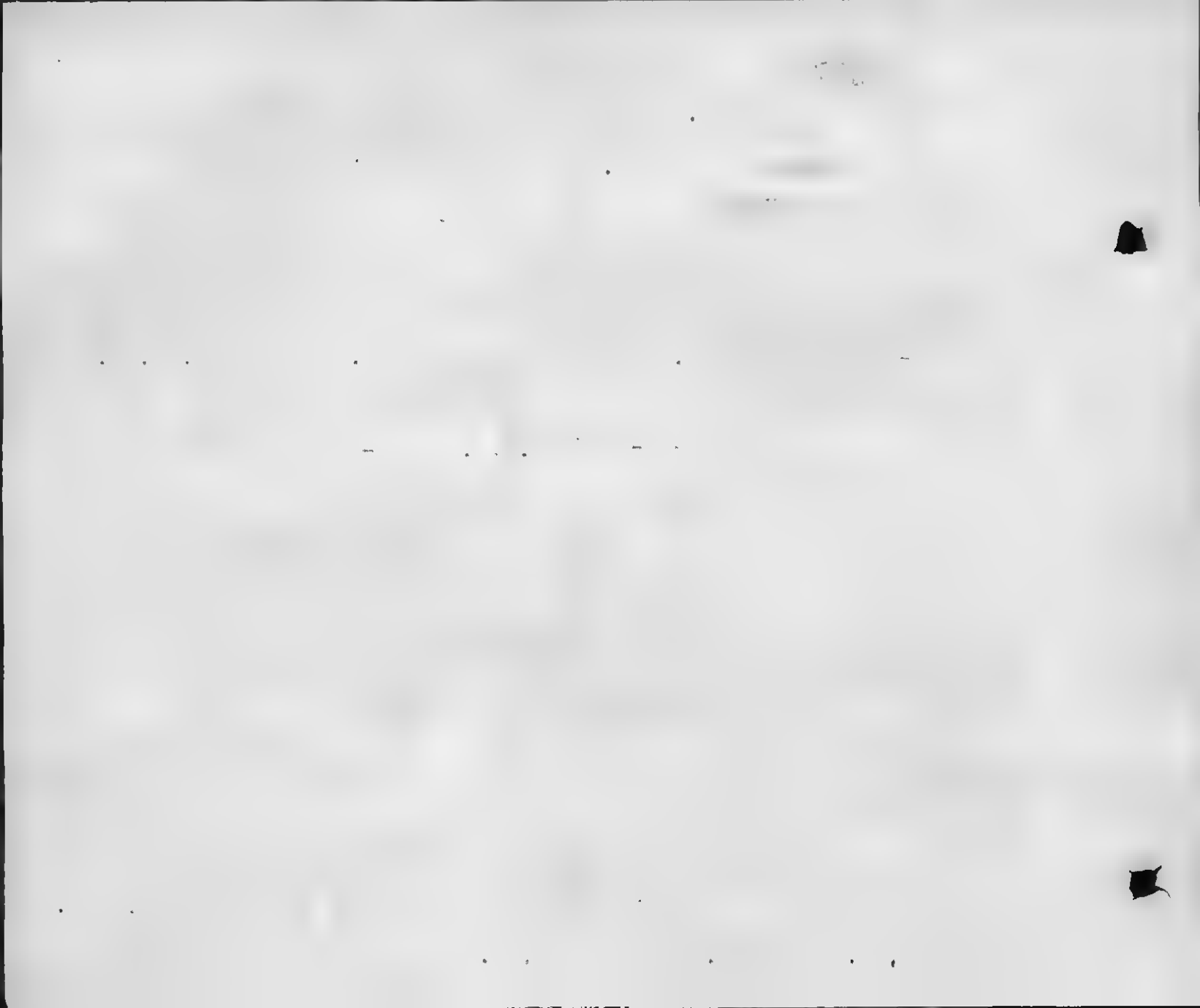
CERTIFICATE OF DEATH

8337

08331

M

1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Landover Hills	
c. LENGTH OF STAY IN lb 13 da.		d. STREET ADDRESS 4417 - 72nd Avenue	
d. NAME OF HOSPITAL OR IN (if not in hospital, give street address) 2601 Cheverly Avenue Adasorda Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Lou Harper		4. DATE OF DEATH July 1 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Dept. store	
11. BIRTHPLACE, County & State, or foreign country Pinson, Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Henry Miller		14. MOTHER'S MAIDEN NAME Nancy Luntford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 411-16-1985	
17. INFORMANT Mrs. C.G. Morris		Address same as above 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE			
420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO GENERALIZED ARTERIOSCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL THROMBOSIS - 1 year ago			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. 19 p.m. 19		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun 1961 to Jun 1961 , that (I) no last saw the deceased alive on 1 Jul 1961 , and that death occurred at 7:05p M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas G. Maloney		22b. DATE SIGNED 1 Jul 61	
22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY M.D.		22d. ADDRESS 4814-71st Ave Landover Hills Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/61	
23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		25a. REC'D BY REGISTRAR Washington, D.C.	
25b. REGISTRAR'S SIGNATURE Charles S. Hines		DATE JUL 5 '61	



FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

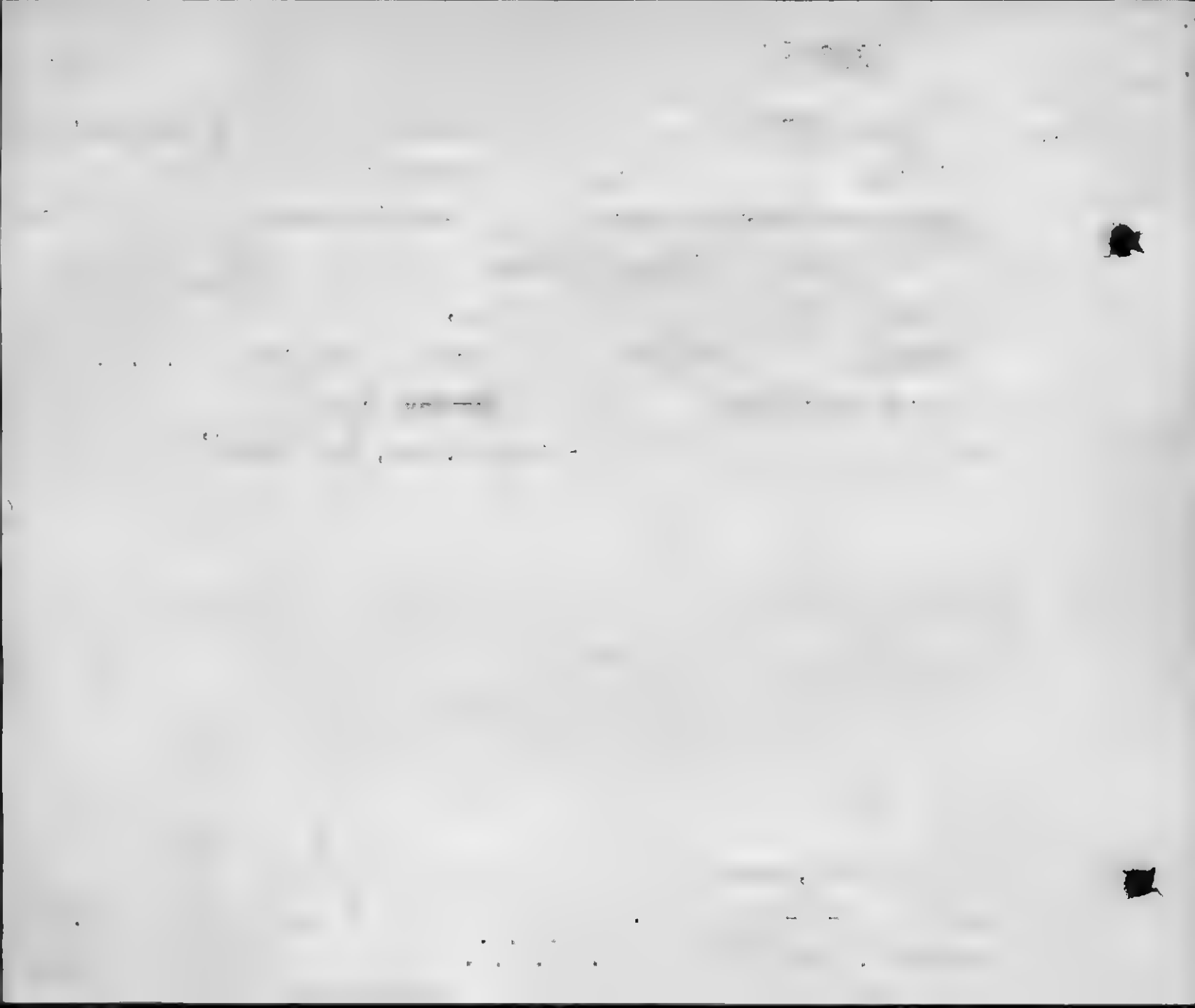
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8338

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08332

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if last full one; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rivdale				c. LENGTH OF STAY IN lb 13 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS Hyattsville			
3. NAME OF DECEASED (Type or print) Mary Elizabeth Hasko				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE (In years last birthday) 60 yrs.		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME Patrick Henry Moran				14. MOTHER'S MAIDEN NAME Josephine Scanlon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give number and dates of service) No				16. SOCIAL SECURITY NO. 578-28-0539			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT MIDDLE and RIGHT LOWER LOBES 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) Right Lower LOBES (c), stating the underlying cause last, DUE TO (c)				17. INFORMANT'S NAME Richard H. Pugh, West Minister Md Address 163 Penn Ave.,			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE HEREON 7-10-61			
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				22d. LOCATION (City, town, or country) (State) Prince Georges			
23. FUNERAL DIRECTOR Francis J. Collins				24a. REC'D BY REGISTRAR JUL 10 '61			
23b. ADDRESS 7821 14th. St. N.W.				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

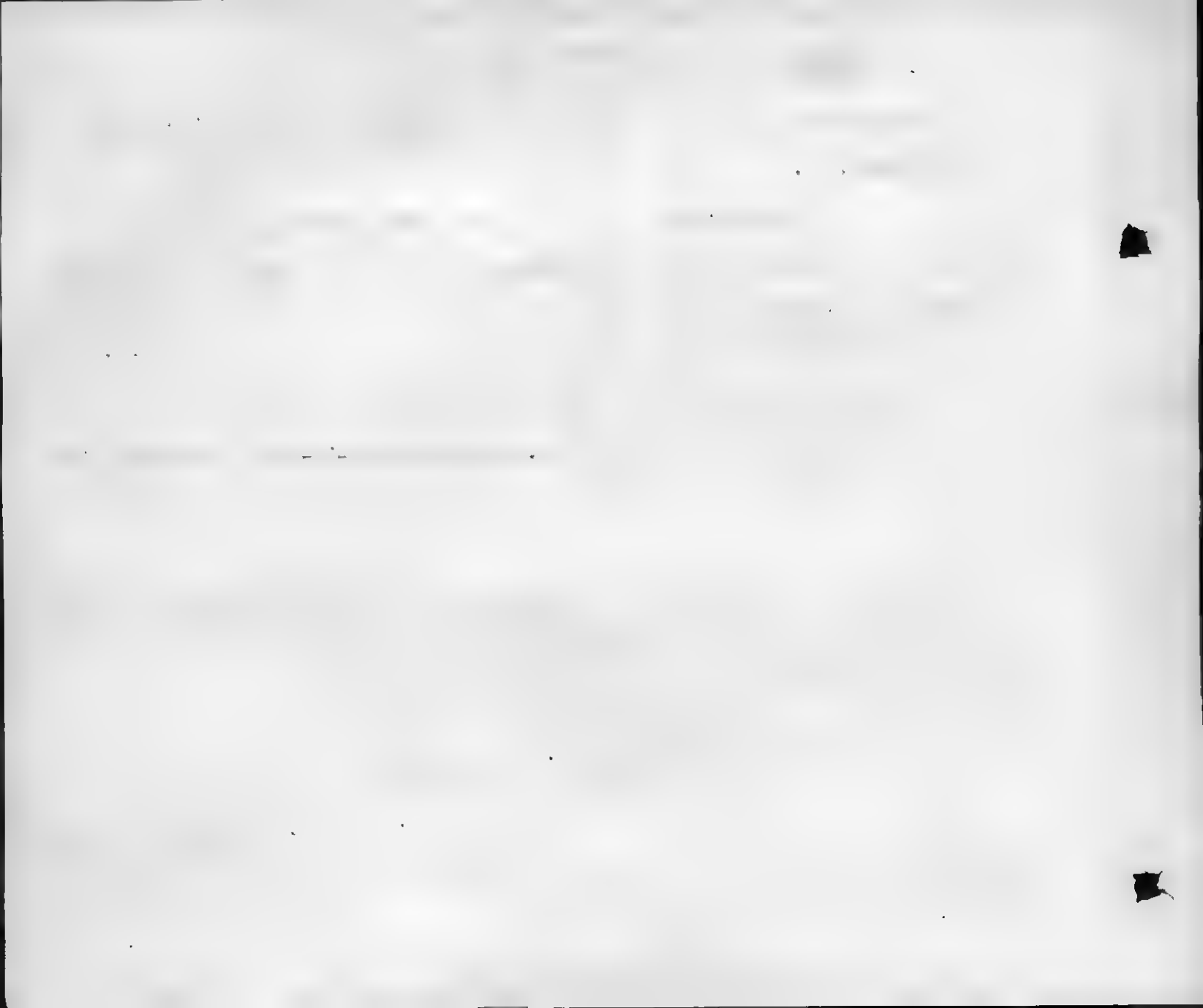
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8339

CERTIFICATE OF DEATH

Reg. Dist. No. 08333

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4473 Forte Drive				d. STREET ADDRESS 4473 Forte Drive			
3. NAME OF DECEASED (Type or print) First Lela Middle Hathaway Last Hathaway				4. DATE OF DEATH Month July Day 26 Year 1961			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 7 Days 7 Hours 7 Min. 7		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Franklin Keller				14. MOTHER'S MAIDEN NAME Elmira Skidmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (1) yes, give war or dates of service				16. SOCIAL SECURITY NO. 292-24-6858		17. INFORMANT Mr. Byron Pope (Son-in-law) 4473 Forte Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis (b) Coronary insufficiency (c) Arteriosclerotic heart disease							
DUE TO 420.0 DUE TO (MANY) YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adria (b) Fibrillation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-25 , 19 59 , to 7-26 , 19 61 , that I last saw the deceased alive on 7-26-61 , 19 61 , and that death occurred at 5:15 PM , from the causes and on the date stated above							
ACTUAL SIGNATURE W.B. Sheer				DATE SIGNED 7-26-61			
PHYSICIAN'S NAME (Type) WALTER B. SHEER				ADDRESS 1200 Northboro Pike			
22a. BURIAL, CREMATION, REINTERMENT (Specify)				22b. DATE THEREOF July 29, 1961			
22c. NAME OF CEMETERY OR CREMATORY North Cem.				22d. LOCATION (City, town, or county) (State) West Mansfield Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lees				ADDRESS 300-4th St. N.E. Wash D.C.			
24a. REC'D BY REGISTRAR JUL 28 1961				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08334

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

B.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
(Type or print)

Mildred Taylor

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

Never Married

WIDOWED

DIVORCED

8. DATE OF BIRTH

February 14, 1913

9. AGE (In years last birthday)

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Emmett Cleveland Taylor

14. MOTHER'S MAIDEN NAME

Gertrude Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ernest Frederick Hauser Jr, Same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒ and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

July 19th., 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 22, 1961

22c. NAME OF CEMETERY OR CREMATORY

Ft Lincoln Cemetery

22d. LOCATION (City, town, or county)

Colmar Manor, Md.

(State)

23. FUNERAL DIRECTOR

ADDRESS

F. Gasch's Sons Hyattsville Md.

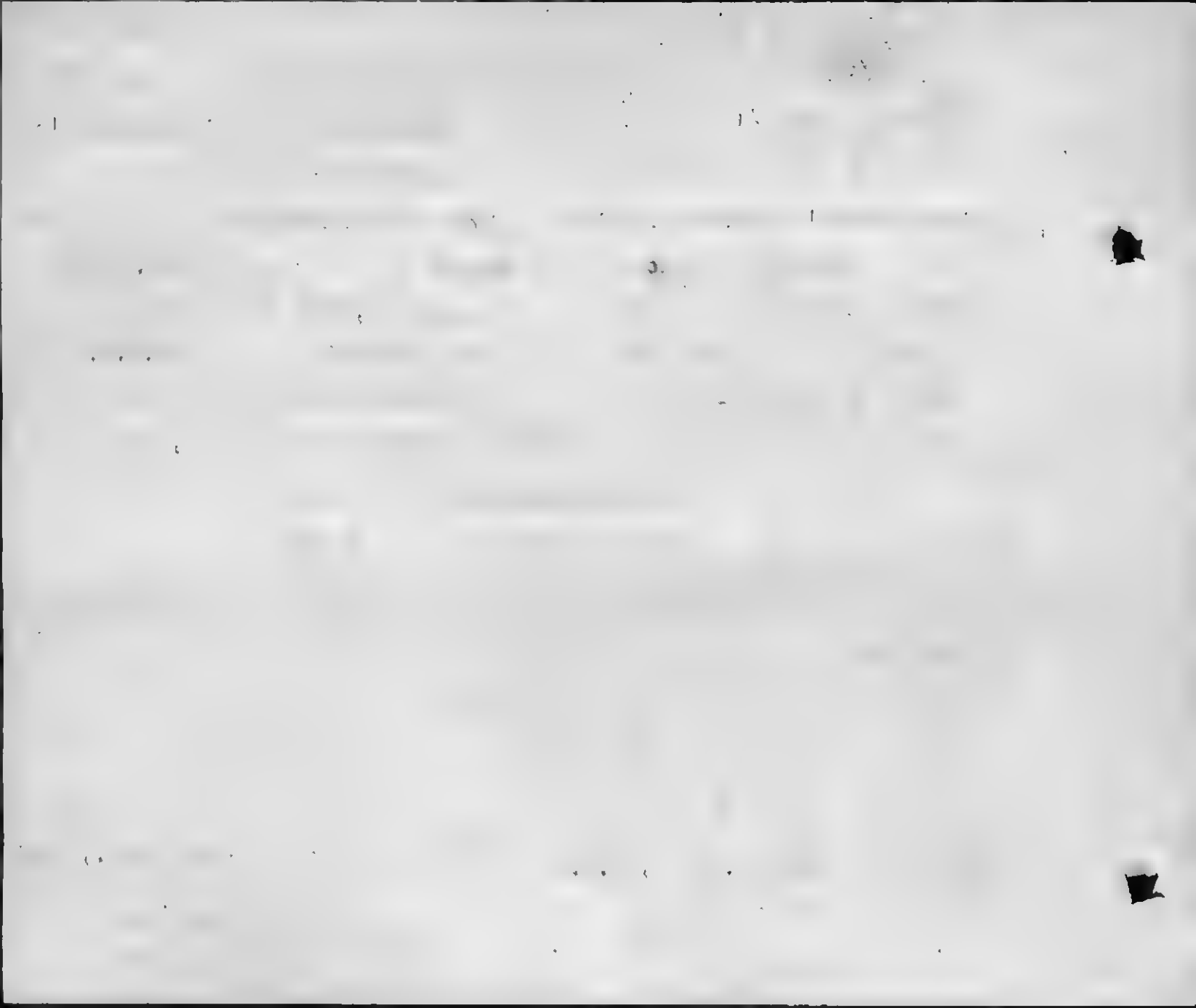
24a. REC'D BY REGISTRAR

DATE JUL 24 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

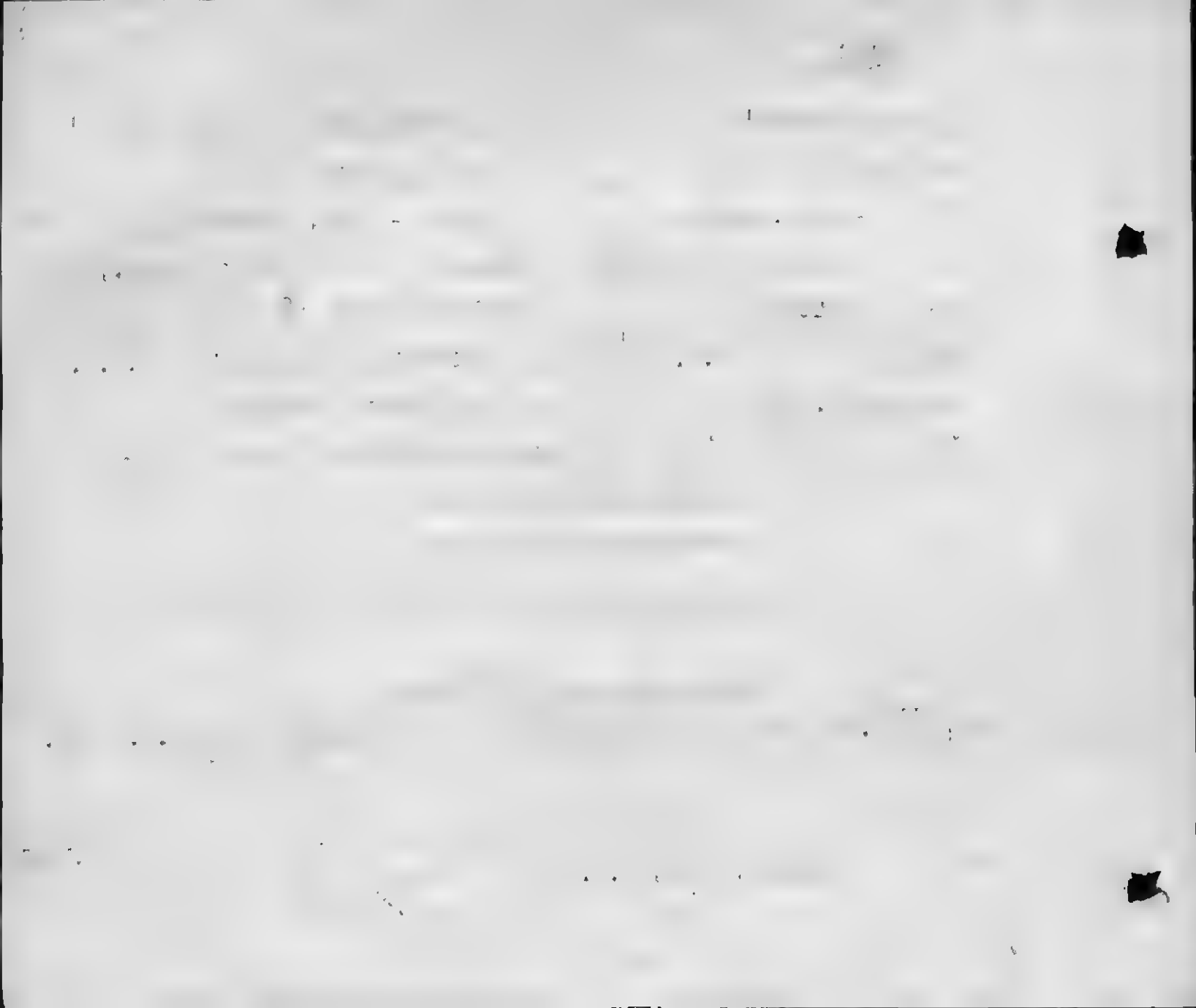
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08335

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3713 - 37th. Avenue		d. STREET ADDRESS 3713 - 37th. Avenue	
3. NAME OF DECEASED (Type or print) James Gordon Helm	4. DATE OF DEATH July 30th, 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 29th, 1919
9. AGE (In years last birthday) 42 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman	11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A. Helm	14. MOTHER'S MAIDEN NAME Mae Veronica Desmond	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 578-05-6547	17. INFORMANT Henrietta Mae Helm Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of mouth (a), stating the underlying cause last, (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Placed shot gun in mouth and fired it		
20c. TIME OF INJURY Month, Day, Year 3:30 a.m. 7/30 1961	20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cottage City P.G. Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-2-1961	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. Bladensburg Maryland	
23. FUNERAL DIRECTOR W.W. Chambers Co. Bethesda Md.	24a. REC'D BY REGISTRAR AUG 2 '61 24b. REGISTRAR'S SIGNATURE William S. Haines		





CERTIFICATE OF DEATH

Reg. Dist. No.

08337

8343

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arondale	c. LENGTH OF STAY IN 1b 70 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arondale, Maryland 49	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2020 Woodroove Road		d. STREET ADDRESS 2020 Woodroove Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CLARENCE MIDDLE WILSON HERMAN		4. DATE OF DEATH Month July 10 th Day Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26, 1894 66 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Carlisle, Penna.
13. FATHER'S NAME Harry H. Herman		14. MOTHER'S MAIDEN NAME Mary Frances Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address above William C. Herman
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis & myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 18 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 1. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1954, to 7/10, 1961, that I last saw the deceased alive on 7/2, 1961, and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Hugh W. Grey</u> M.D. 7105 - RIGGS RD, 7/10/61 PHYSICIAN'S NAME (Type) <u>HUGH W. GREY</u> HYATTSVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/13/61	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 13 '61	24b. REGISTRAR'S SIGNATURE William C. Herman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



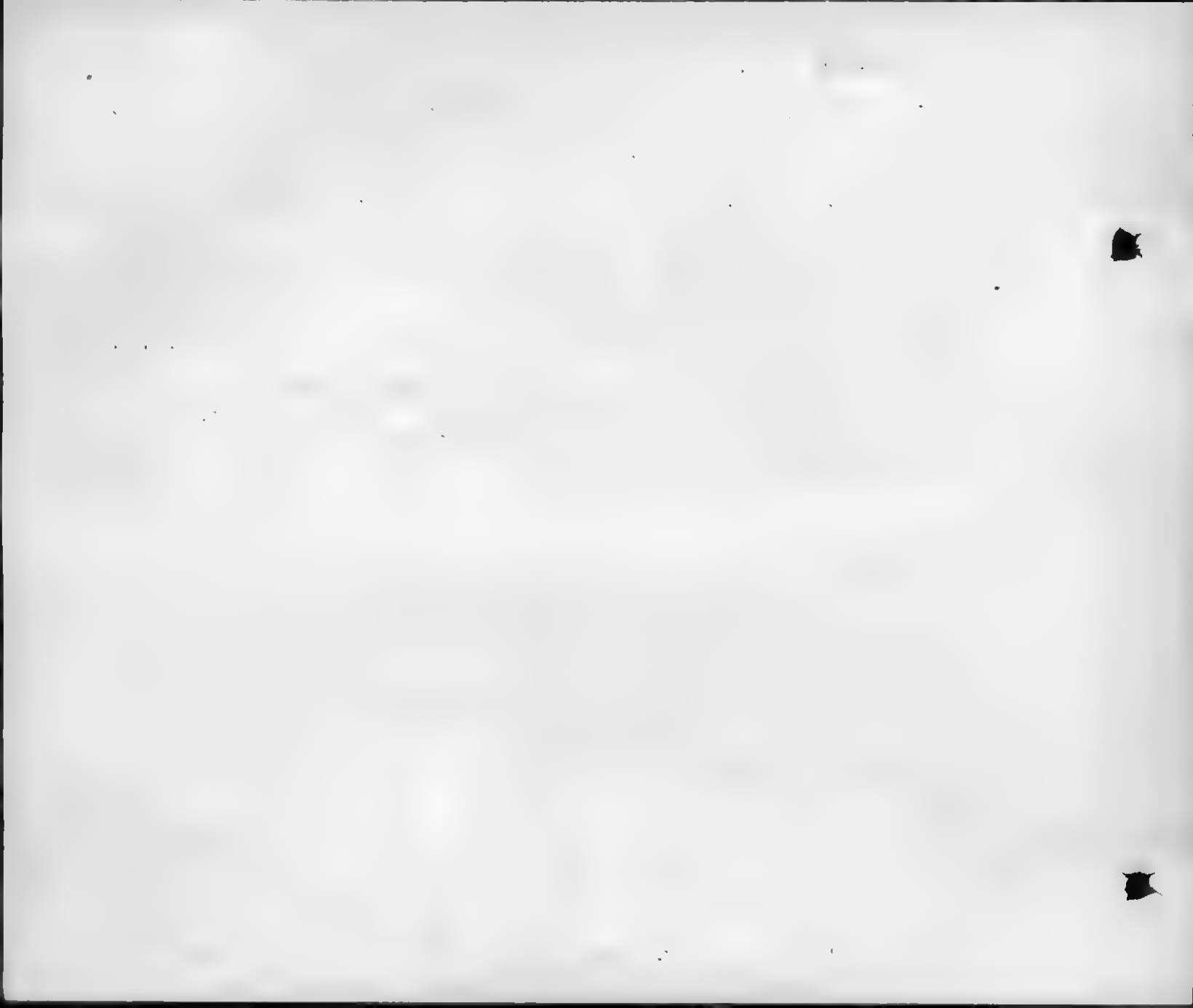
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8344

08338

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5602 Queenschapel Road		d. STREET ADDRESS 5602 Queenschapel Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mrs Grace Hoffman		4. DATE OF DEATH Month Day Year July 25 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William McLuckie		14. MOTHER'S MAIDEN NAME Ida Virginia Gunnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Truston Cannon		Address 4021 Longfellow Street Hyattsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS 151X DUE TO Adeno CARCINOMA OF STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to 7/25 1961 , that (I) (we) last saw the deceased alive on 7/25 1961 , and that death occurred at 11:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Norman Donat Comerau M.D.		22b. DATE SIGNED 7/25/61	
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMERAU		22d. ADDRESS 3503 PENNY ST MT RAINIER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/28/61	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town, or county) (State) Easton Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE Charles L. Kline	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

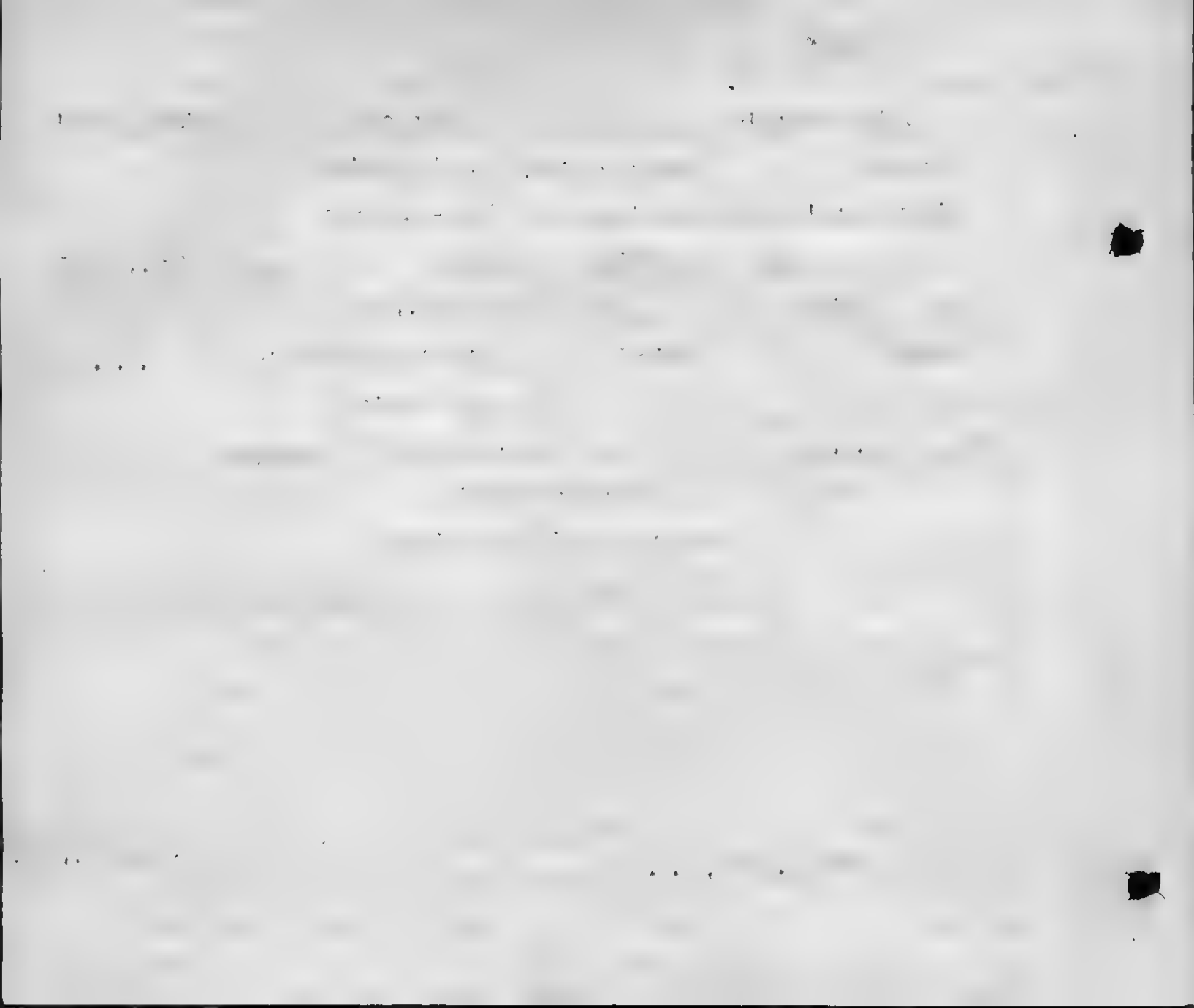
VS. A15ME
5M 9/60

8345
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		d. STREET ADDRESS 6402 - A Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Hopkins				4. DATE OF DEATH July 7th., 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23rd., 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retired		9. AGE (In years last birthday) 68 yrs.		11. BIRTHPLACE (State or foreign country) District of Columbia	
13. FATHER'S NAME James Holden				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				14. MOTHER'S MAIDEN NAME Anne Hopkins			
16. SOCIAL SECURITY NO. W.W. 1				17. INFORMANT Georgie Holden Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Commnary Occulsion							
DUE TO Arteriosclerotic Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED July 8th., 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-1961		22c. NAME OF CEMETERY OR CREMATORY Arlington Hall		22d. LOCATION (City, town, or country) (State) 28 Myer, Va.	
23. FUNERAL DIRECTOR Robert A Mattingly		ADDRESS Wash DC		24a. REC'D BY REGISTRAR 131-11488		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8346

CERTIFICATE OF DEATH

Reg. Dist. No. 08340

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE -- b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forestville Nursing Home				d. STREET ADDRESS 3237 Hiatt Place, N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Virginia M. Howdershell				4. DATE OF DEATH Month Day Year July 22, 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/16/1883	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Cogan				14. MOTHER'S MAIDEN NAME --- Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 577-07-0882D			
17. INFORMANT Address Forestville, Maryland Records at Nursing Home - Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Occlusion of coronary artery DUE TO (b) arteriosclerosis of coronary artery DUE TO (c) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from 12-1-1960 to 7-22-1961, that I last saw the deceased alive on 7-21-1961, and that death occurred at 3:03 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard Gitter				ADDRESS (Street, city or town, state) 656 EAST CAP. ST. WASH. 3, D.C.			
PHYSICIAN'S NAME (Type) RICHARD GITTER				DATE SIGNED 7-22-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/61		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR DATE JUL 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

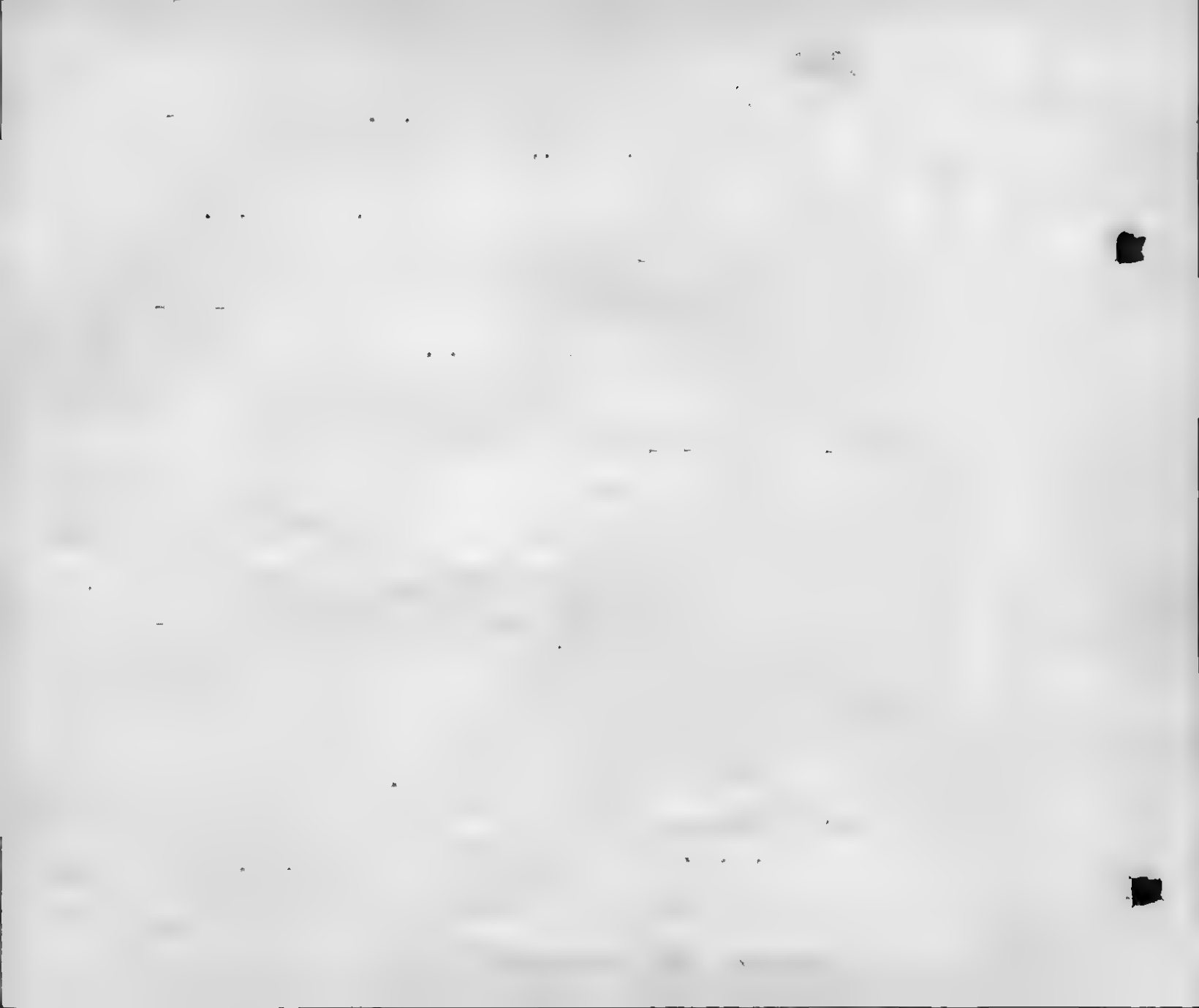
8347

CERTIFICATE OF DEATH

8347

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Glenn Dale (rural) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 330 Va., Ave., S. E.			
3. NAME OF DECEASED (Type or print) Preston Hymes				4. DATE OF DEATH Month 7 Day 10 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/17/19 41 yrs.	
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Potomac Fish Market		9. AGE (In years last birthday) 41 yrs.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cattie Hymes				14. MOTHER'S MAIDEN NAME Minnie Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 577-18-0782			
17. INFORMANT Decedent				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Aspiration left empyema with bronchopleural-cutaneous fistula DUE TO (c) Left upper lobectomy & wedge superior segment left lower lobe (4/4/61) for far advanced pul. tbc. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) Diabetes mellitus, partial gastrectomy 1950, right pulmonary decortication 10/54, right thoracoplasty 1/55.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/20/ 59 to 7/10 61 , that (I) (we) last saw the deceased alive on 7/10 19 61 , and that death occurred at P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 7/10/1961			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-14-61		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION (City, town or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines				25a. REC'D BY REGISTRAR 3015-12th St. N.E. D.C.			
25b. REGISTRAR'S SIGNATURE Arthur L. Harris				DATE JUL 18 '61			

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

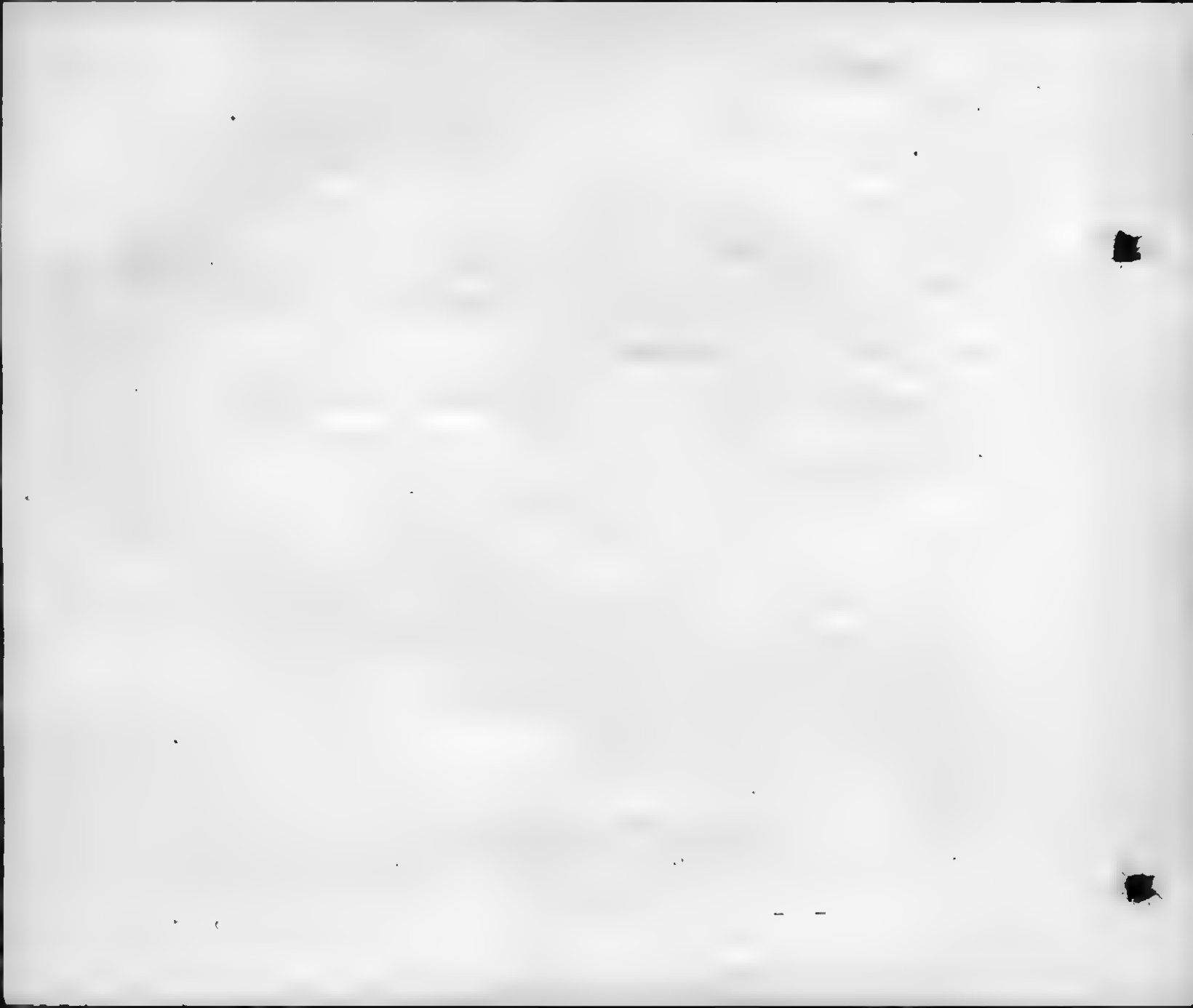
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8348

08342

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges, Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Switland				c. LENGTH OF STAY IN lb 23 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Switland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hittie Cox Johnson				4. DATE OF DEATH Month Day Year 7/23/1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/71	
9. AGE (In years lost birthday) 89 yrs		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME BENJAMIN COX				14. MOTHER'S MAIDEN NAME HANNAH ELIZABETH ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MRS. Geo. C. Miller Address 3425 - 82nd Ave. N. Forrestville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Insufficiency (c) Longstanding Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Pneumonia, Pyelonephritis INTERVAL BETWEEN ONSET AND DEATH Immediate 18-10yr? 20 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to July 23, 1961 , that (I) last saw the deceased alive on July 22, 1961 and that death occurred at 10:30 AM on the causes and on the date stated above.							
22a. SIGNATURE Kelvin L. Minchin M.D.				22b. DATE SIGNED July 23 1961		22c. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN M.D.	
22d. ADDRESS 7200 MARLBORO PIKE WASH 28 D.C.				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-27-61		23c. NAME OF CEMETERY OR CREMATORY Farmington		23d. LOCATION (City, town, or county) (State) Farmington, N. Hampshire	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. L. L. ADDRESS 300 4th ST N.E.				25a. REC'D BY REGISTRAR DATE JUL 26 '61		25b. REGISTRAR'S SIGNATURE W. L. L.	

(M)



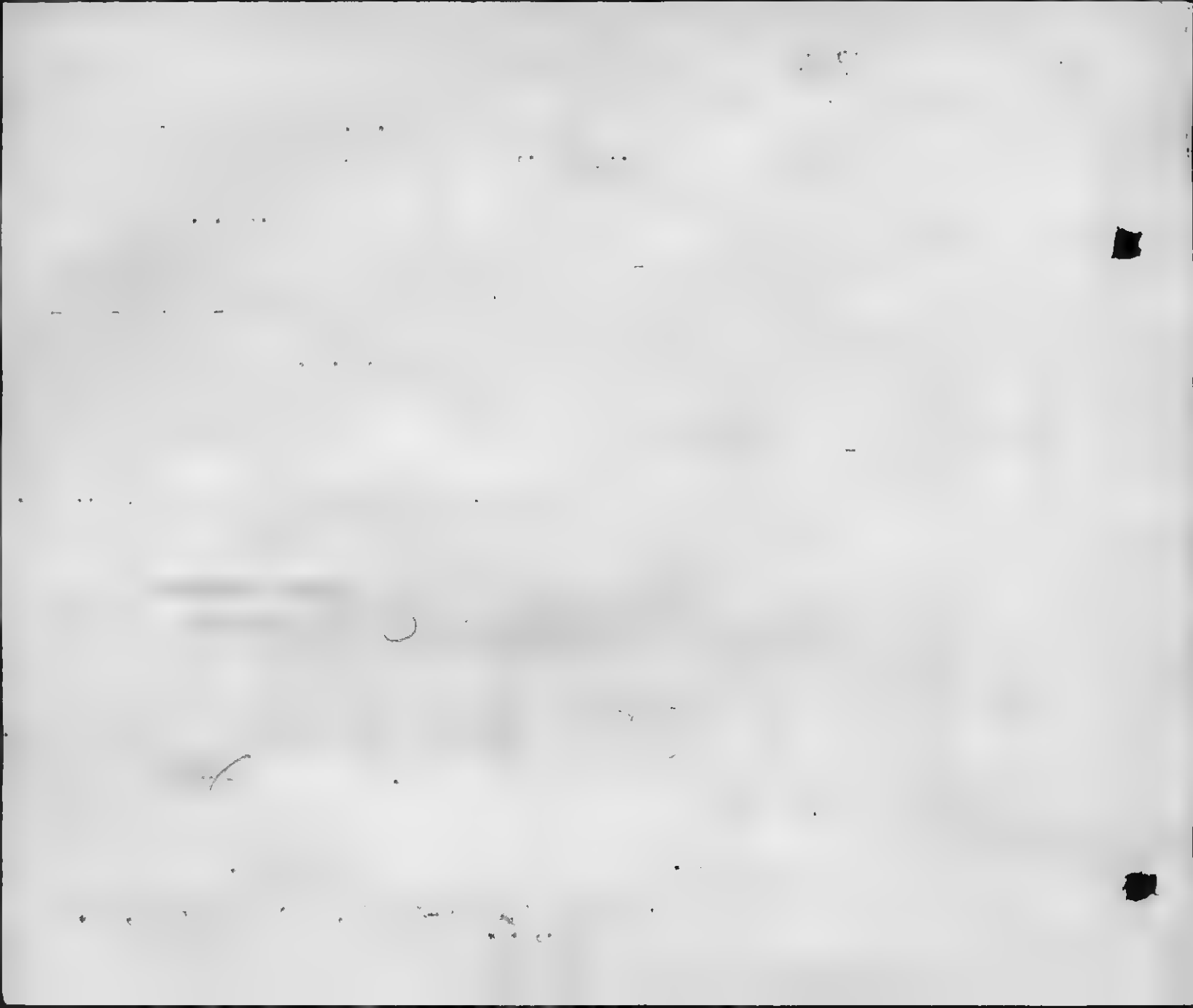
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

** insufficiency with gangrene of both feet

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
8349			
08343			
1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1341 14th St., S.W.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY in 1b 3 yrs., 4 mos., & 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Johnson		4. DATE OF DEATH 7 22 1961	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/11/1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days 7 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ed Johnson		14. MOTHER'S MAIDEN NAME Ida Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus; bilateral pyelonephritis; pulmonary emphysema and fibrosis; early cirrhotic changes in the liver; peripheral vascular **			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER!)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/28/1958 to 7/22/1961 that (I) (we) last saw the deceased alive on 7/22/1961 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 7/22/1961	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 7-24-61		23b. DATE THEREOF July 27, 1961	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City, town or county) (State) Huntsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Melvin Schrey Inc.		25a. REC'D BY REGISTRAR JUL 26 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Evans			

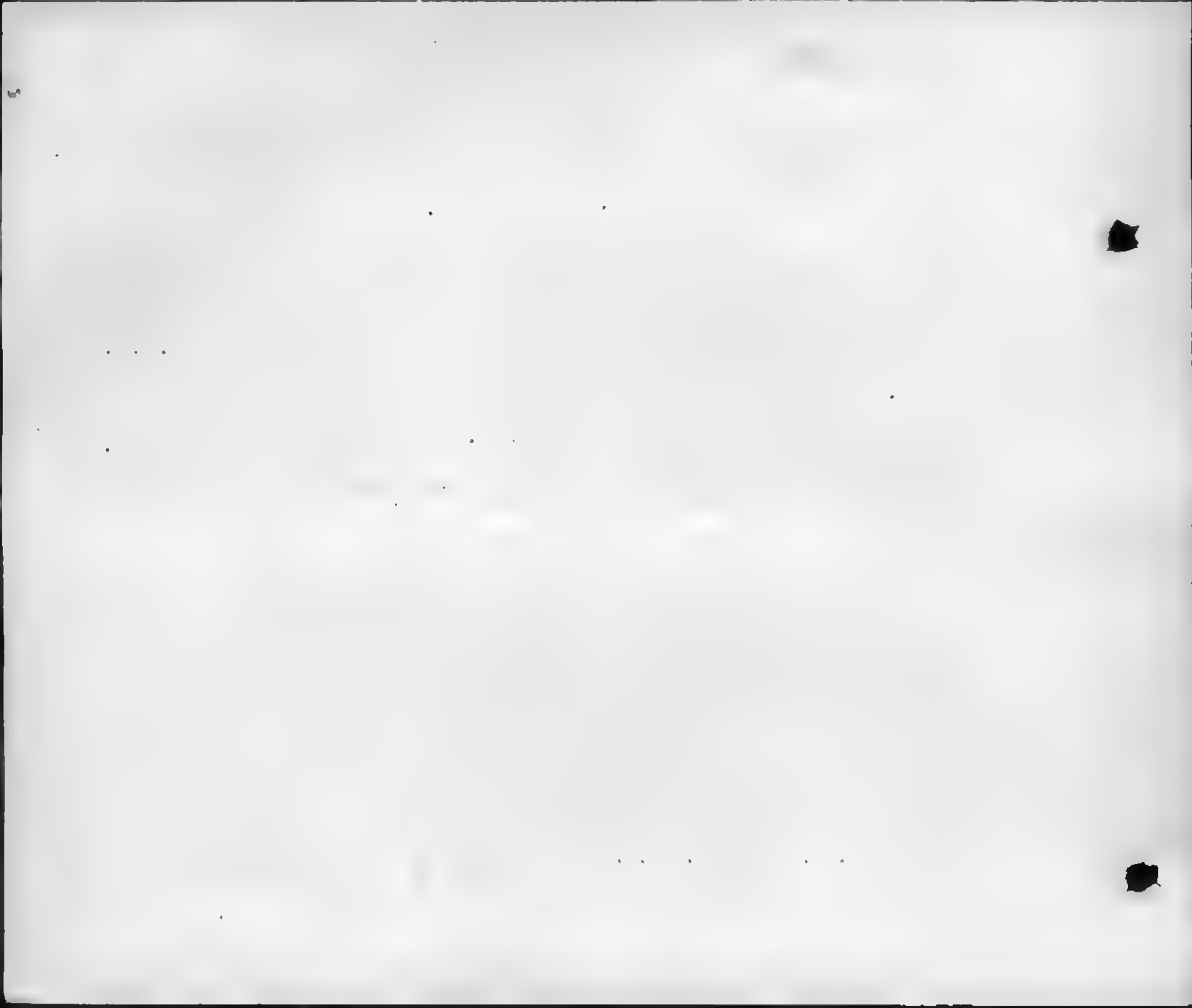


TO HEALTH OFFICIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
4
8350
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08344

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Et. 2 Box 411		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emmett L Johnston				4. DATE OF DEATH Month Day Year July 17 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 June 1899	
9. AGE (In years last birthday) 62 yrs.		10. AGE (In years last birthday) 62 yrs.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President Colonial Oldsmobile				10b. KIND OF BUSINESS OR INDUSTRY Colonial Oldsmobile		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Elmer L. Johnston				14. MOTHER'S MAIDEN NAME Laura Field			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO ?		17. INFORMANT Mrs. H. Lewis Britts	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured diverticulum sigmoid</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Central accident - complication</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psycho-cystitis</u>				INTERVAL BETWEEN ONSET AND DEATH 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 1958 to July 17, 1961, that (I) (we) last saw the deceased alive on July 17, 1961, and that death occurred at 6:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Donald D. Mitchell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. D. Mitchell., M.D.				22d. ADDRESS 1746 K St NW, Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 7/19/61		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Roanoke, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.A. Hines Co.				ADDRESS 2901-14 St. S.W.		25a. REC'D BY REGISTRAR DATE JUL 19 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2351

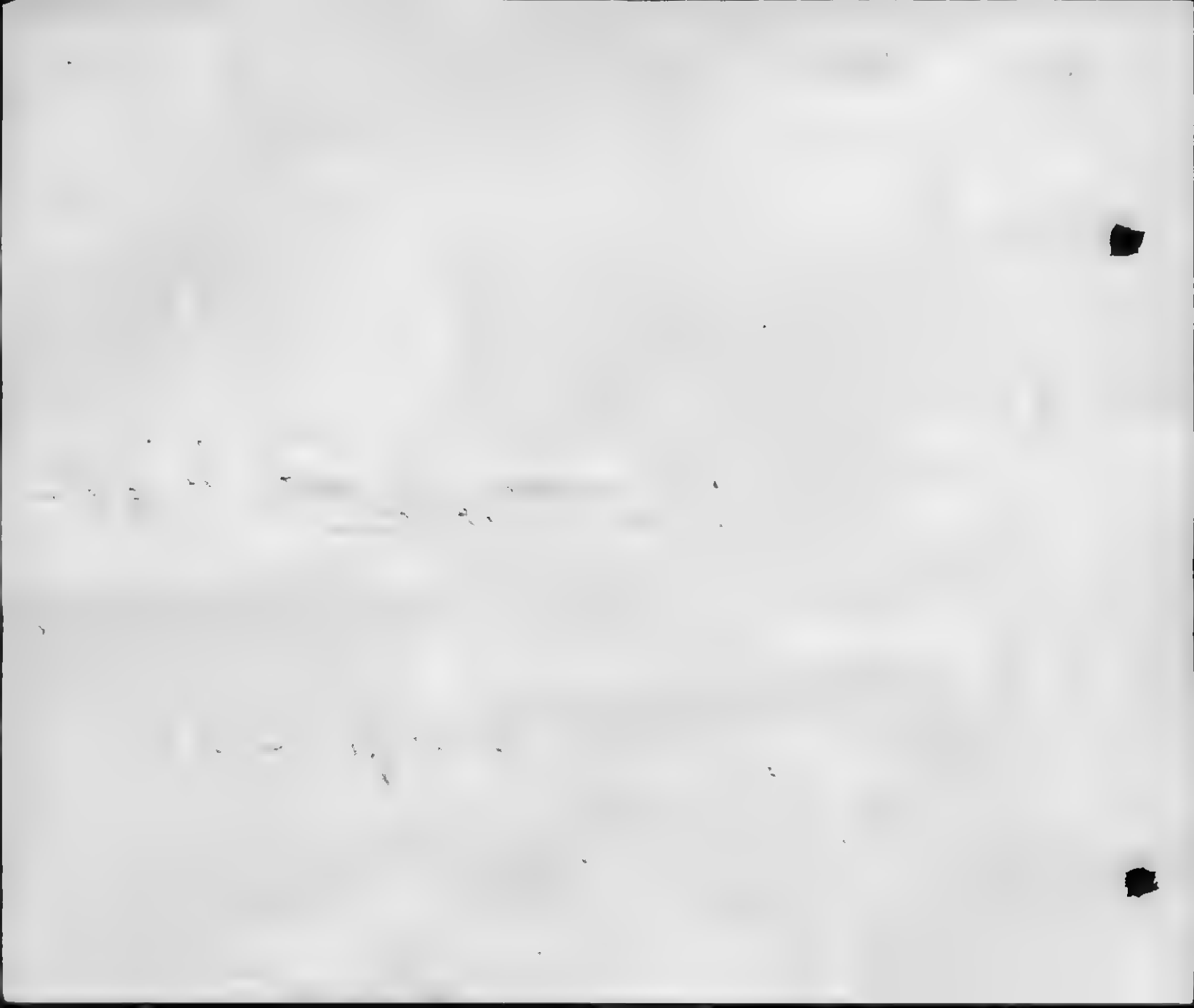
CERTIFICATE OF DEATH

Items 3 & 14 Film 0292-8/8/61 iwk

08345

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Riverdale</u> c. LENGTH OF STAY IN TB <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Meland Memorial</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5025 38th Ave</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annabelle R. Jones</u>		4. DATE OF DEATH <u>July 20 1961</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 23, 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ashe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>George M Jones</u> Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with General Metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>170X</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1961</u> to <u>July 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 20, 1961</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>LW Malin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-20-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LW Malin MD</u>		22d. ADDRESS <u>Riverdale Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Washington D C</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



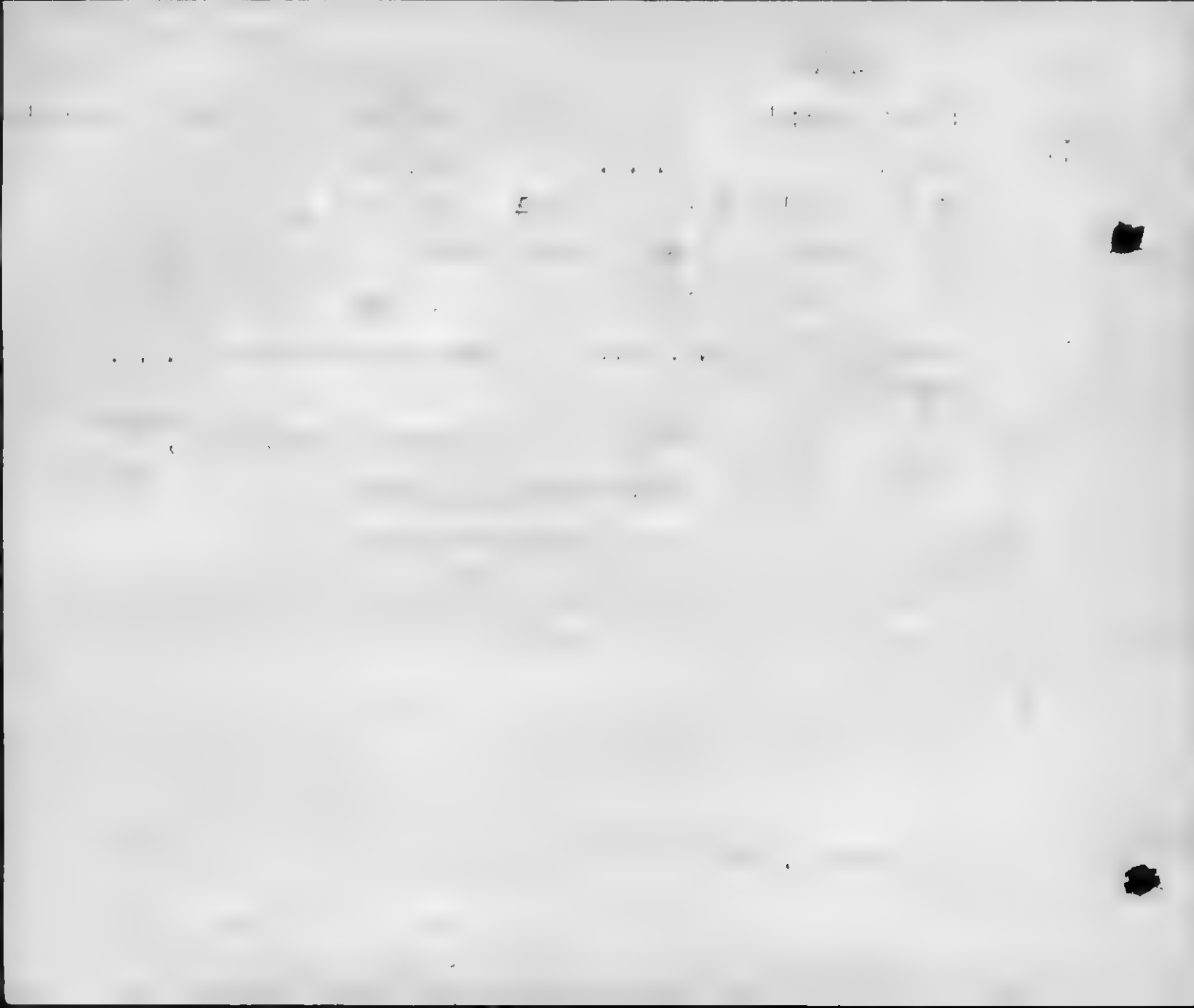
1
FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9,60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
0352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08346											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sunnybrook d. STREET ADDRESS 5522 Volta Ave					
3. NAME OF DECEASED (Type or print) Arthur Clifford Jones						4. DATE OF DEATH July 27 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1888		9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt				11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Jones						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Marjorie Rollins. Tuxedo, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular Renal Disease (c) Cardiovascular Renal Disease (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						DATE SIGNED 7/28/61					
EXAMINER'S NAME (Type) James I. Boyd						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 7-31-1961		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Switland Maryland	
23. FUNERAL DIRECTOR Robert A Mattingly						ADDRESS 131-11 St SE		24b. REC'D BY REGISTRAR JUL 31 '61		24c. REGISTRAR'S SIGNATURE Cirino S. Hume	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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M

2353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08347

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Maryland b. COUNTY Montgomery Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Belle Mead			
f. STREET ADDRESS 7401 Tilden Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Jones Last Jones				4. DATE OF DEATH Month 7 / Day 3 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/5/89	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 7 Days 3	IF UNDER 24 HRS Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Asst. Div. Head. Revenue		10b. KIND OF BUSINESS OR INDUSTRY U.S. Internal		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Jones				14. MOTHER'S MAIDEN NAME Emma J. Billard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Irene Bradley Jones Address 7401 Tilden St. Belle Mead, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 160X DUE TO Autorespiratory Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Diabetes Mellitus (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis of Both Knees							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Belle Mead	(County) Montgomery	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 6:26 19 61 to 7:3 19 61 that (I) (we) last saw the deceased alive on 7:3 19 61 and that death occurred at 9:02 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE Cl. Deary		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/3/61			
22c. PHYSICIAN'S NAME (Type) Cl. Deary		22d. ADDRESS 1756-6a. Queen					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-7-1961	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery, Silver Spring, Md.		23d. LOCATION (City, town, or county) (State) Silver Spring, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gorman, Inc.		ADDRESS 1756-6a. Queen		25a. REC'D BY REGISTRAR Jul 7 '61	25b. REGISTRAR'S SIGNATURE C. C. Gorman		



1
FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the medical director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
C8343											
1. PLACE OF DEATH a. COUNTY Prince George's						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights					
c. LENGTH OF STAY IN 1b 1 year						d. STREET ADDRESS 2411 Farley Place					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2411 Farley Place						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Theodore Keen			First Middle Last			4. DATE OF DEATH July 14 1961			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1922		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner				10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William Warren Brockington				14. MOTHER'S MAIDEN NAME Thedasia Keen				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 577-26-0909				17. INFORMANT Mildred Keen 3007 Erie St., S.E. Wash., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound in the head. (c) DUE TO (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Self inflicted gun shot wound of the head.							
20c. TIME OF INJURY Month, Day, Year 11:55 AM 7/14/61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
								20f. (City or town) Hillcrest Hgts P.G. (County) Md. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7/15/61			
NAME (Type) Dr. James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7.19.1961				22c. NAME OF CEMETERY OR CREMATORY Arlington National			
								22d. LOCATION (City, town, or country) Arlington Virginia (State)			
23. FUNERAL DIRECTOR J. L. Jones 3004 4th St. N.E. Wash. D.C.				ADDRESS				24a. REC'D BY REGISTRAR DATE JUL 20 '61			
								24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

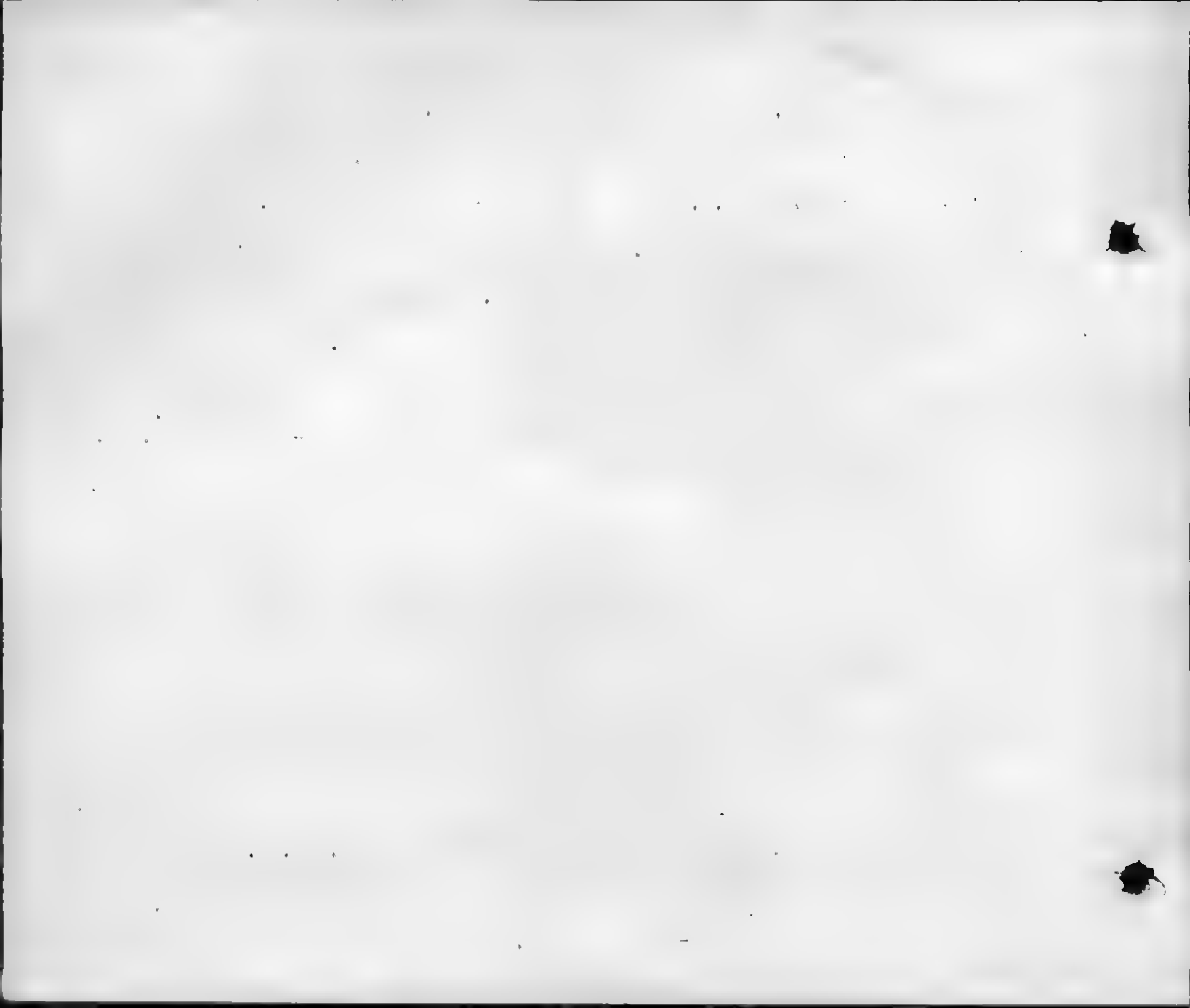


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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8355
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
C8349

1 PLACE OF DEATH COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE DC. b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park		c LENGTH OF STAY IN lb 2 Days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC. 42X			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2306- Gaylord Street S.E.				d. STREET ADDRESS 1438- 18th Street S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First ANNIE Middle M. Last KERNS				4. DATE OF DEATH Month July Day 26th Year 19 61			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25th 1890	9 AGE (In years last birthday) yrs 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Doyle				14. MOTHER'S MAIDEN NAME Mary Burns			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO None		17 INFORMANT Charles P. Howard, 2007- Lakewood St. SE. Address Wash., 23, DC			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Acute Cardiac Insufficiency Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive heart disease (c) Hypertension DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 days 20 yrs + 20 yrs +						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G-VEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 19 41 to July 26 1961, that (I) (we) last saw the deceased alive on July 24 1961, and that death occurred at 3:15 P.M. from the causes and on the date stated above							
22a SIGNATURE James C. Cawood M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED July 26-61	
22c PHYSICIAN'S NAME (Type) JAMES C. CAWOOD				22d ADDRESS 2520- Pa. Ave., S. E. Washington, DC			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF July 28- 1961		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City, town, or county) (State) Suitland, Maryland.	
24 FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1661- Good Hope Rd. SE Washington DC		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Krens			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8356

CERTIFICATE OF DEATH

08350

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY in 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> d. STREET ADDRESS <u>5415 67th. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Vola</u> <u>May</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-20-1896</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A. Balt. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Arnold unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Hospital Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>Septicemia</u> DUE TO (c) <u>Urinary Tract Infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHF, cystocele, rectocele, goiter</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>61</u> to <u>July 4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 4</u> , 19 <u>61</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R.H. Sandstrom</u>		22b. DATE SIGNED <u>7-5-61</u>		22c. PHYSICIAN'S NAME (Type) <u>R.H. Sandstrom</u>			
22d. ADDRESS <u>16202 Lantier Lane, Silver Spring Md.</u>		23a. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>					
23b. DATE THEREOF <u>7-8-1961</u>		23c. LOCATION (City, town or county) <u>Suitland, Maryland</u>		23d. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>			
25c. ADDRESS <u>5801 Cleveland Ave.</u>		25d. DATE <u>JUL 10 '61</u>		25e. (City, town or county) <u>Riverdale, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8357

CERTIFICATE OF DEATH

08351

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie, Maryland</u> d. STREET ADDRESS <u>Lanham Severn Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>E.</u> Last <u>Kimball</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 61</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1-1-83</u>							
9. AGE (In years birthday) <u>78</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>							
12. CITIZEN OF WHAT COUNTRY? <u>America</u>											
13. FATHER'S NAME <u>Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Eva Lina Moss</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Hospital Records Riverdale, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral thrombosis</u> <u>partial Rt. hemiplegia</u> <u>General arterio sclerosis</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>not</u> <u>July 22, 1961</u> to <u>July 22, 1961</u> , that (I) <u>not</u> last saw the deceased alive on <u>July 22, 1961</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>L. W. Malin</u>		22b. ADDRESS <u>Riverdale, Md 7-22-61</u>		22c. PHYSICIAN'S NAME (Type) <u>L. W. Malin M.D.</u>							
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial</u> <u>7/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>JUL 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



8358

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02352

Item 14 from birth cert. 8/2/61 iwk

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 5046 Dixon Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby		Middle Boy		Last Kocher		4. DATE OF DEATH Month July		Day 31 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 July 1961		9. AGE (In years last birthday) — yrs	10. IF UNDER 1 YEAR Months 15	11. IF UNDER 24 HRS Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harrison Kocher				14. MOTHER'S MAIDEN NAME Patricia Jean Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia RLL RML 762.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961, to July 31, 1961, that (I) (we) last saw the deceased alive on July 30, 1961, and that death occurred at 6:15 AM from the causes and on the date stated above.									
22a. SIGNATURE Lewis Parker			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/31/61				
22c. PHYSICIAN'S NAME (Type) Dr. Parker., M.D.			22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/3/61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town, or county) Cheverly, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator				25a. REC'D BY REGISTRAR DATE AUG 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram			

2177233 XV4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8359

08353

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines c. LENGTH OF STAY IN 1b Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6314 Patterson Road		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines d. STREET ADDRESS 6314 Patterson St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle A. Last Kumm		4. DATE OF DEATH Month July Day 27 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14, 1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Seiler		14. MOTHER'S MAIDEN NAME Caroline Schube	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Henry Kumm		Address East Pines, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 DUE TO <i>my phosorus comas</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15 1961, to July 27th 1961, that (I) (we) last saw the deceased alive on July 27th 1961, and that death occurred at 10:25 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Vin Benjamin Cummings</i>		22b. DATE SIGNED July 27, 1961	
22c. PHYSICIAN'S NAME (Type) TILL BERGEMANN		22d. ADDRESS 534 Greenbelt Road Greenbelt	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/61	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		25a. REC'D BY REGISTRAR DATE AUG 3 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>James S. Hines</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

8360

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08354

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 wks 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton (Rural)			
f. STREET ADDRESS Rural				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Norman Middle L. Last Lucas				4. DATE OF DEATH Month July Day 27 Year 1961			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1893	
9 AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min. 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter--Retired		10b. KIND OF BUSINESS OR INDUSTRY General Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ned Lucas			
14. MOTHER'S MAIDEN NAME Betty Swann				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO 578-18-4339				17 INFORMANT Address Clara E. Leonberger, 1905--17th St. S.E. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. DUE TO (b) Gastric Resection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Renal de-Minety							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from 7-8-1961 to 7-27-1961, that (I) (we) last saw the deceased alive on 7-27-1961, and that death occurred at 2:28 PM, from the causes and on the date stated above							
22a. SIGNATURE A. Bannick				22b. DATE SIGNED 7.27.61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS P. G. C. H.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				25a. REC'D BY REGISTRAR JUL 28 61			
ADDRESS 514 11th St. S.E.				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8361

00355

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. STREET ADDRESS 5725 - 43rd Avenue			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Martin				4. DATE OF DEATH Month July Day 24 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1886	
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min 15		11. IF UNDER 24 HRS Months 7 Days 15 Hours 15 Min 15		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles M. Martin				14. MOTHER'S MAIDEN NAME Laura Robey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 718-14-9097		17. INFORMANT 1730 Peachtree Lane Mrs. Mary Nippes Norristown, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia RML RLL 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Care to the rectum DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 2-4 1960 to 2-25 1961 , that (I) (we) last saw the deceased alive on 2-25 1961 , and that death occurred at 9:00 AM , from the causes and on the date stated above							
22a. SIGNATURE A. Decker				22b. DATE SIGNED P.M.		22c. PHYSICIAN'S NAME (Type) A. Decker	
22d. ADDRESS Hyattsville, Md.				22e. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) Colmar Manor, Md. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR JUL 27 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna				25c. REGISTRAR'S SIGNATURE Arthur S. Hanna			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

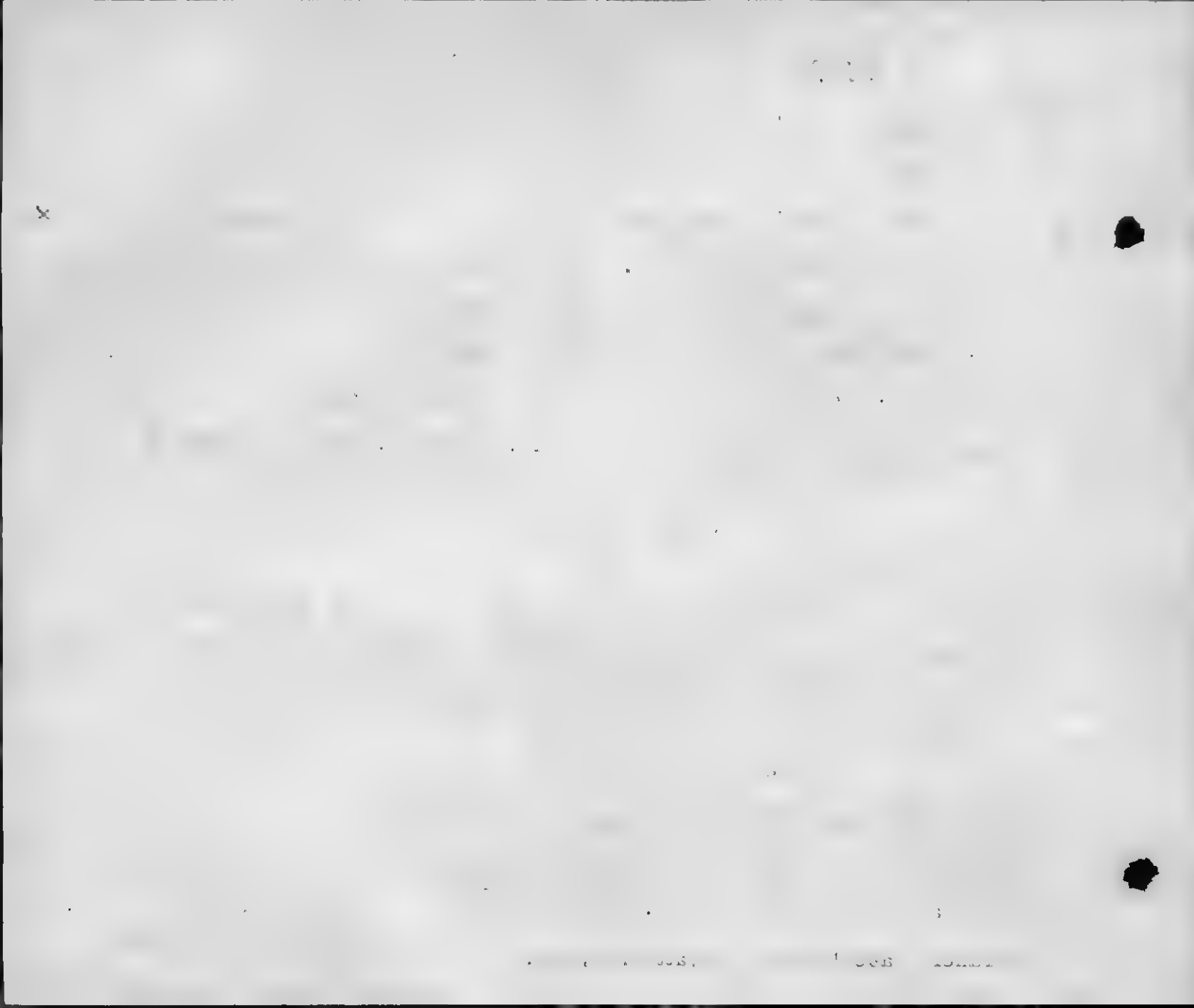
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8362

CERTIFICATE OF DEATH

98356

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park d. STREET ADDRESS 6526 Coolidge Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George C. Martin First Middle Last 4. DATE OF DEATH July 11 19 61 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3/22/88 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Steamfitter 10b. KIND OF BUSINESS OR INDUSTRY Self 11. BIRTHPLACE (County & State, or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George C. Martin 14. MOTHER'S MAIDEN NAME Harriett Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1 16. SOCIAL SECURITY NO. WW 1 17. INFORMANT Mrs. Myrtle M. Martin Same as # 2 (Wife) Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY INFARCTS 764X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO Thrombophlebitis, LEFT Femoral 7 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) aenebale Thrombosis right INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) aenebale Thrombosis right		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/27 19 61 to 7/11 19 61 , that (I) (we) last saw the deceased alive on 7/11 19 61 and that death occurred at 3:05 PM from the causes and on the date stated above.			
22a. SIGNATURE Norman D. Donat 22c. PHYSICIAN'S NAME (Type) Norman D. Donat		22b. DATE SIGNED 7/11/61 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 3503 PERRY ST MT RAINIER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/14/61		23c. NAME OF CEMETERY OR PLACE OF BURIAL Ft. Lincoln 23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 14 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

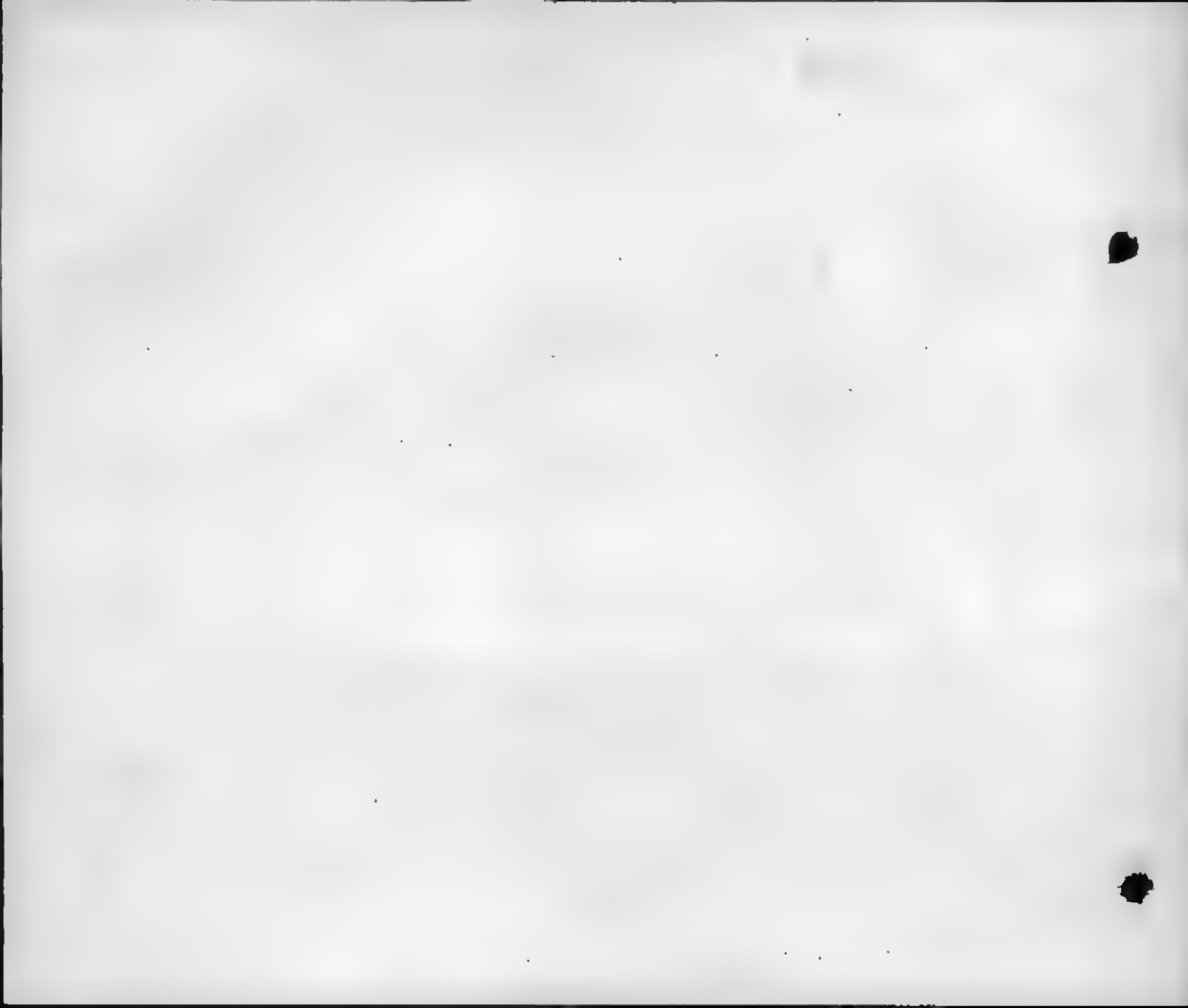
8363

83357

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b 29 days			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Adolph Middle P. Last Mattia				4. DATE OF DEATH Month July Day 24 Year 19 61			
5 SEX Male		6 COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH March 28, 1902	
9 AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months 5 Days 14 Hours 11 Min.		IF UNDER 24 HRS Months 5 Days 14 Hours 11 Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY Office Machines		11 BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sylvia Mattia				14. MOTHER'S MAIDEN NAME Nicolnia Santalli			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. 578-05-5925		17. INFORMANT Esther I. Mattia Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Portai Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) 1+ years				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-26, 1961 , to 7-24, 1961 , that (I) (we) lost saw the deceased alive on 7-24, 1961 , and that death occurred at 11:45 , from the causes and on the date stated above.							
22a SIGNATURE Waldo B. Moyers				ATTENDING PHYSICIAN M D <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Waldo B. Moyers				22d ADDRESS 3503 Perry St. Mt. Rainier Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7/27/61		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
				25b REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Coroner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

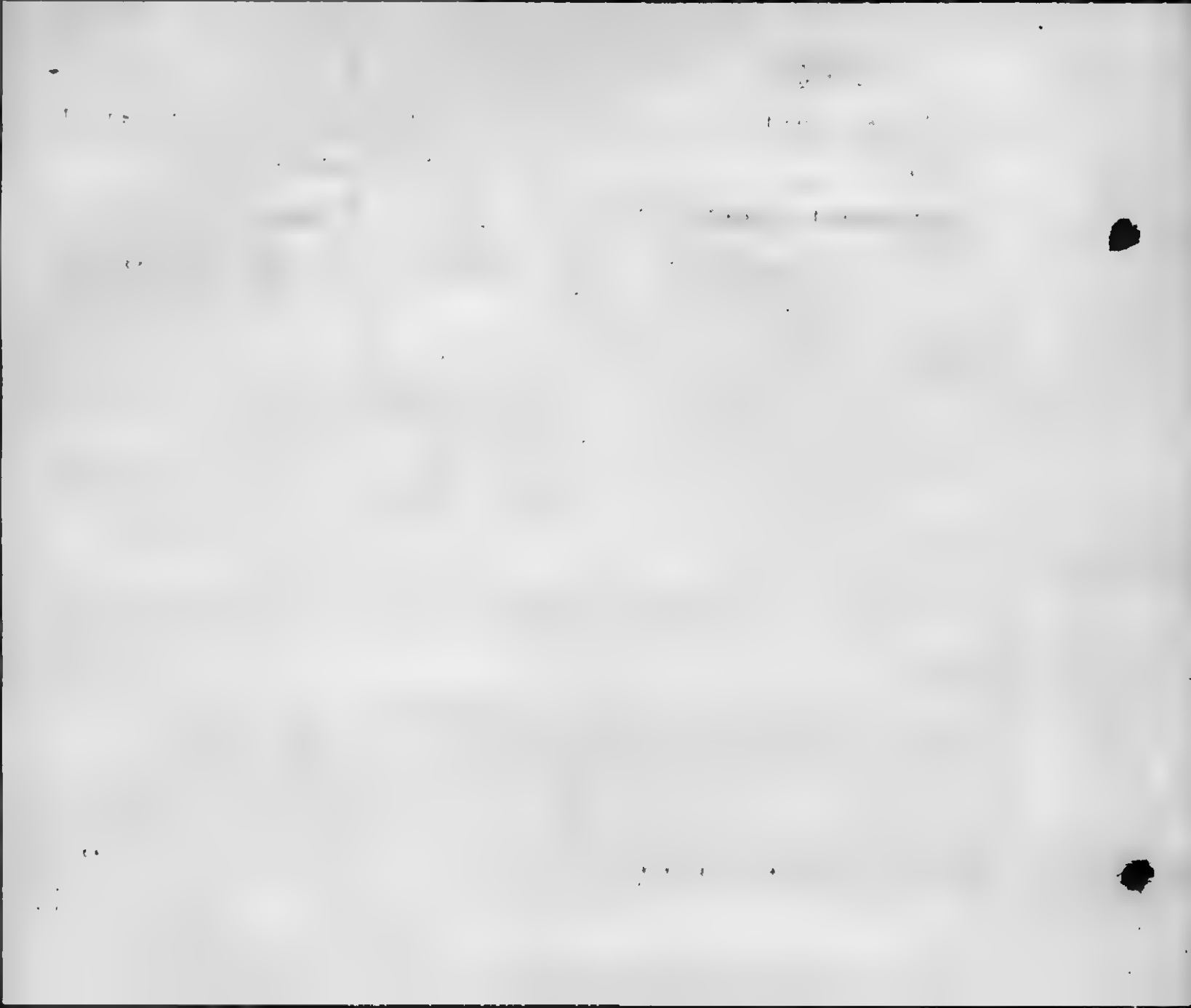
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02359

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clayton	4. DATE OF DEATH Month July Day 13th. Year 1961	5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Last 1102 Middle McLean First 1102	
9. AGE (In years last birthday) 58 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) unknown	12. CITIZEN OF WHAT COUNTRY? unknown
13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT unknown Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated duodenal ulcer DUE TO (b) Generalized peritonitis DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED July 14th., 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8.1.61	
22c. NAME OF CEMETERY OR CREMATORY Vol. Md. Med. School		22d. LOCATION (City, town, or country) (State) Baltimore, Md	
23. FUNERAL DIRECTOR ADDRESS		24a. REC'D BY REGISTRAR AVG 2 '61	
		24b. REGISTRAR'S SIGNATURE William S. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and not filed in by the funeral director. After this certificate has been signed by the attending physician and not filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
5
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8365
8359
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Prince George**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN 1b **4 Days**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Prince George's General Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Prince George**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cheverly**
d. STREET **2516 Crest Ave.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Mamie**
4. SEX **Female**
5. COLOR OR RACE **White**
6. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
7. DATE OF BIRTH **Dec. 29, 1889**
8. AGE (In years, last birthday) **71** yrs.
9. AGE (In years, last birthday) **71** yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife**
11. KIND OF BUSINESS OR INDUSTRY **own home**
12. CITIZEN OF WHAT COUNTRY? **U S A**

13. FATHER'S NAME **Henry A. Applebaum**
14. MOTHER'S MAIDEN NAME **Gertrude**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no**
16. SOCIAL SECURITY NO. **579 44 9986**
17. INFORMANT **Mary M Steninger**
Address **Cheverly, Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE **Bronchopneumonia**
(b) DUE TO **Cardiovascular**
(c) DUE TO **Cerebral thrombosis**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) **Diabetes mellitus**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year **June 19, 1961**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **June 19, 1961** to **July 8, 1961**, that (I) (we) last saw the deceased alive on **July 8, 1961**, and that death occurred at **10 A.M.** from the causes and on the date stated above.

22a. SIGNATURE **William Rosson** M.D.
22b. PHYSICIAN'S NAME (Type) **Dr. William Rosson, M.D.**
22c. ADDRESS **5701 85th Ave, Hyattsville, Md.**

23a. BURIAL, CREMATION, or other disposal of body **Burial**
23b. DATE THEREOF **July 11, 1961**
23c. NAME OF CEMETERY OR CREMATORY **Mt Olivet Cemetery**
23d. LOCATION (City, town or county) (State) **Washington D. C.**

24. FUNERAL DIRECTOR'S SIGNATURE **F. Gasch's Sons**
ADDRESS **Hyattsville, Md.**
25a. REC'D BY REGISTRAR **JUL 13 '61**
25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

CHAS. H. K. 1918

1918

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8365

08360

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death on) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>379 Main Street</u>		d. STREET ADDRESS <u>379 Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Nettie C. Millard</u>		4. DATE OF DEATH <u>July 9 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1880</u>
9. AGE (in years last birthday) <u>81</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Benjamin Fadden Thompson</u>	14. MOTHER'S MAIDEN NAME <u>Edna Maryland Flood</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>C. Millard Wilcox</u>		17. INFORMANT <u>Dr. Bond Smith</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 720.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Myocardial Infarction - Coronary Disease</u> (c) <u>Arterio-Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 8 1957</u> to <u>July 9 1961</u> , that (I) (no) last saw the deceased alive on <u>July 8 1961</u> , and that death occurred <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Wingfield</u>		22b. DATE SIGNED <u>July 9, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Buried July 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>	
23d. LOCATION (City, town or county) <u>Calverton</u>		(State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. W. H. Connelley, Lanham, Md</u>		25a. REC'D BY REGISTRAR <u>JUL 13 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Farris</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8367

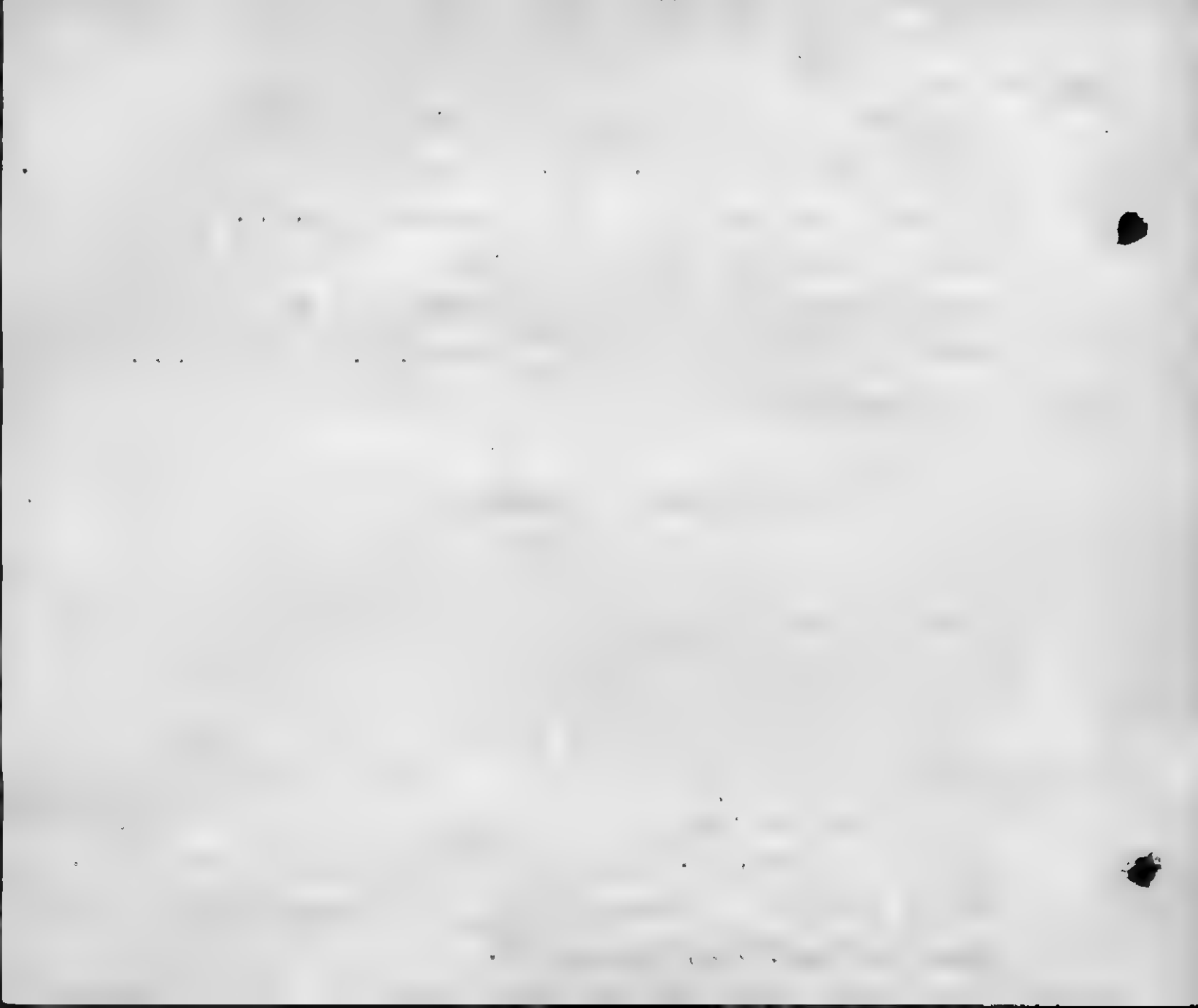
CERTIFICATE OF DEATH

08361

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. LENGTH OF STAY IN 1b 1 mo. 20 das.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY District of Columbia		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1225 Emerson Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Glenn Dale Hospital		First Hiram		Middle Albert		Last Minor		4. DATE OF DEATH Month July		Day 8		Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1882		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 8		IF UNDER 24 HRS. Hours 19 Min 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Waterford, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Daniel Webster Minor		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Person		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]														INTERVAL BETWEEN ONSET AND DEATH approx 7 mo.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the right lung DUE TO (b) (Histologic type unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatitis, etiology undetermined														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 18 19 61 , to July 8 19 61 , that (I) (we) last saw the deceased alive on July 8 19 61 , and that death occurred 4:20 A.M. , from the causes and on the date stated above.															
22a. SIGNATURE Moe Weiss				M.D. Moe Weiss, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.				22b. DATE SIGNED July 8, 1961			
23a. BURIAL OR CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 7/11/61				23c. NAME OF CEMETERY OR CREMATORY Hamilton				23d. LOCATION (City, town or county) (State) Landon Co. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Theron Wheeler F. H. Hines				ADDRESS Rockville Md.				25a. REC'D BY REGISTRAR DATE JUL 11 '61				25b. REGISTRAR'S SIGNATURE Charles S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

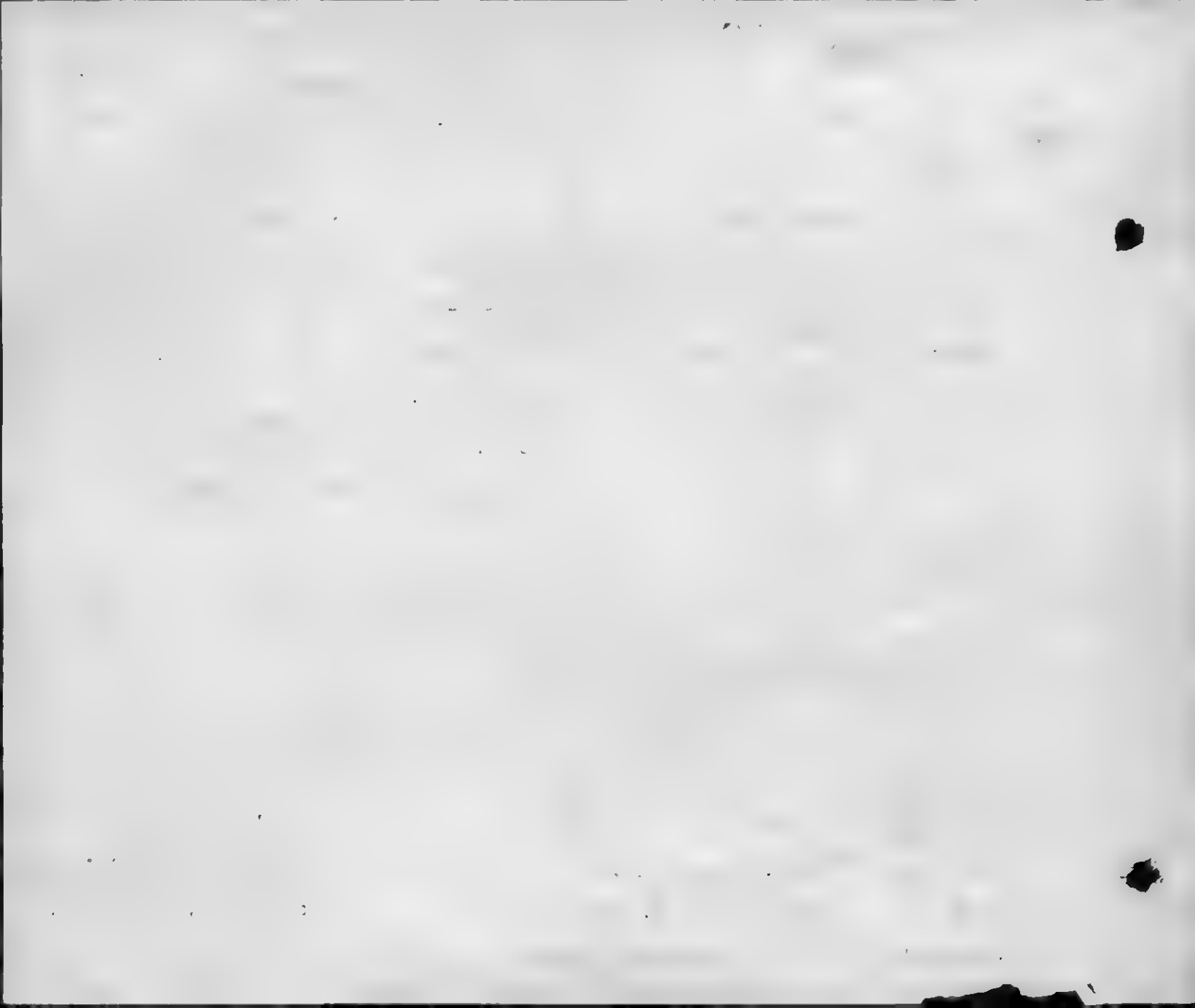
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8368

98362

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IN- 12 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
f. STREET ADDRESS 4806 52nd Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eldridge W. Morris		4. DATE OF DEATH Month July Day 15 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-10-15	
9. AGE (in years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min.	
11. BIRTHPLACE (Country & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eldridge S. Morris		14. MOTHER'S MAIDEN NAME Lillie N. Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ethel N. Morris	
17. INFORMANT Ethel N. Morris		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Arteriosclerotic Cardiovascular Disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH ?	
21. I certify that (I) (this hospital) attended the deceased from July 14, 1961 to July 15, 1961 , that (I) (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 9:30 AM from the causes and on the date stated above.		22. SIGNATURE William D. Rosson, M.D.	
23. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.		24. ADDRESS 5701 85th Avenue, Carrolton, Md.	
25. REC'D BY REGISTRAR HUL 18'61		26. REGISTRAR'S SIGNATURE William D. Rosson	
27. BURIAL, CREMATION, REMOVAL (Specify) Burial		28. DATE THEREOF 7/18/61	
29. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln		30. LOCATION (City, town or county) (State) Colmar Manor, Md.	
31. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		32. ADDRESS Hyattsville, Maryland	



in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3369

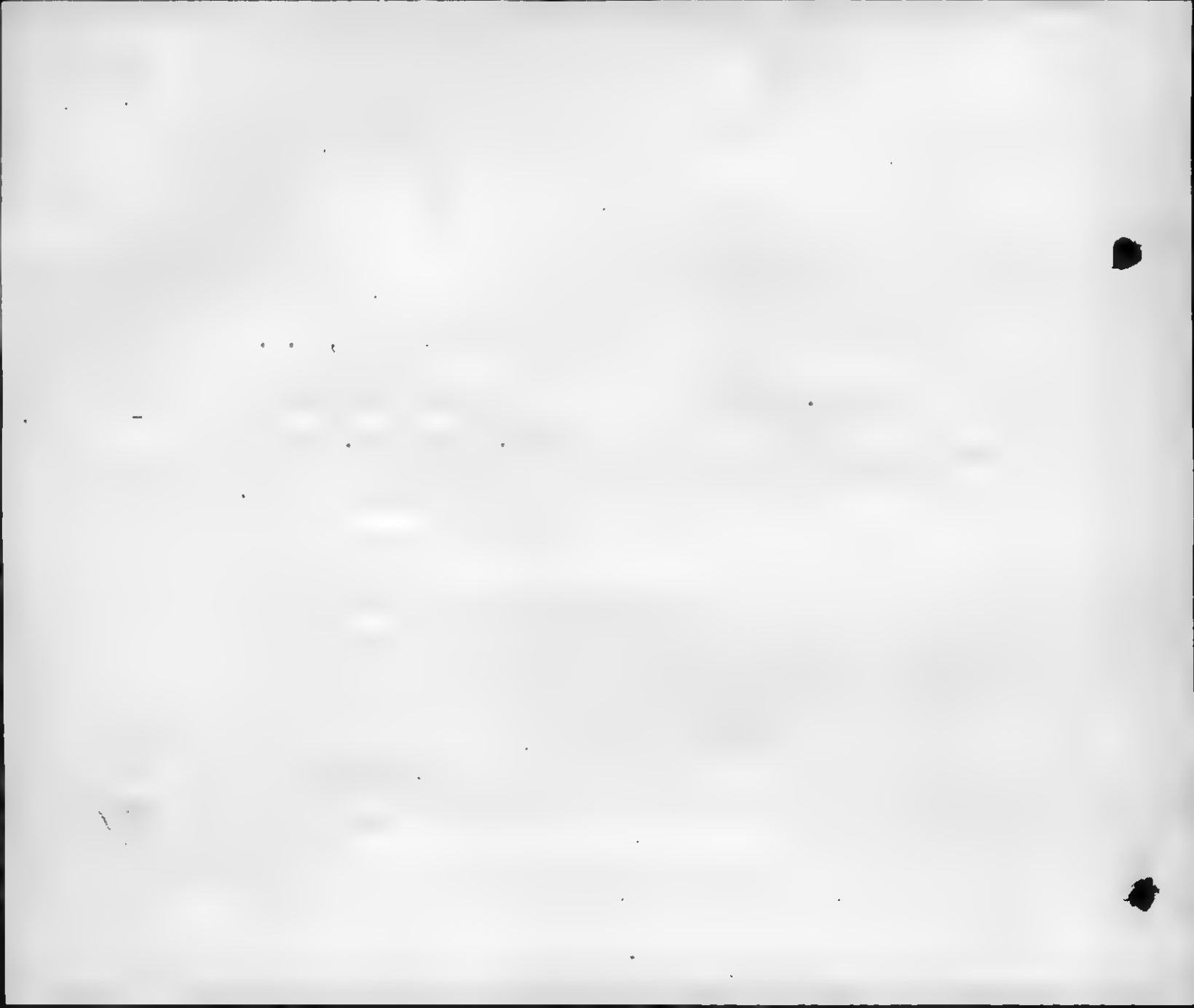
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

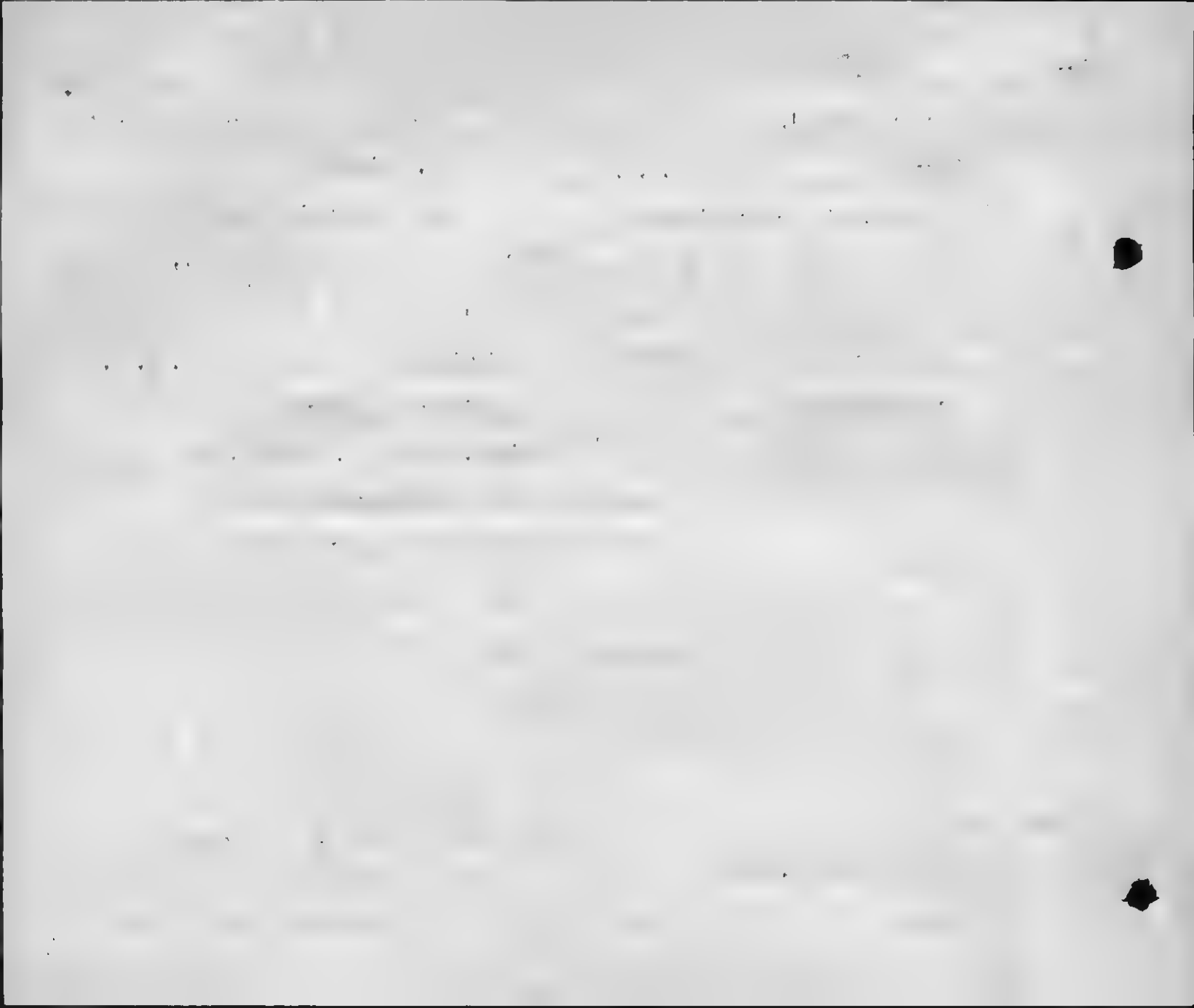
38363

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Washington 21			
				d. STREET ADDRESS 5804 - 24th Place			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle J Last Mow				4. DATE OF DEATH Month July Day 1 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 Feb 1889	
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min 72		IF UNDER 24 HRS Months 72 Days 72 Hours 72 Min 72			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Andrew E. Gray				14. MOTHER'S MAIDEN NAME Josephine Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Dorothy F. Williams	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive left intracerebral hemorrhage 4200 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) arteriosclerosis of the heart DUE TO (c) arteriosclerosis of the heart				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1961 to 1961 , that (I) (we) lost saw the deceased alive on 7-1-1961 , and that death occurred 5:55 AM from the causes and on the date stated above.							
22a. SIGNATURE William D. Lesson				22b. DATE SIGNED 7/1/61			
22c. PHYSICIAN'S NAME (Type) Dr. Lesson				22d. ADDRESS 5804 - 24th Place			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF July 5 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Wash. D.C.				25a. REC'D BY REGISTRAR DATE JUL 5 '61		25b. REGISTRAR'S SIGNATURE William D. Lesson	

(M)

(I)





14
FOR STATE
HEALTH DEPT.

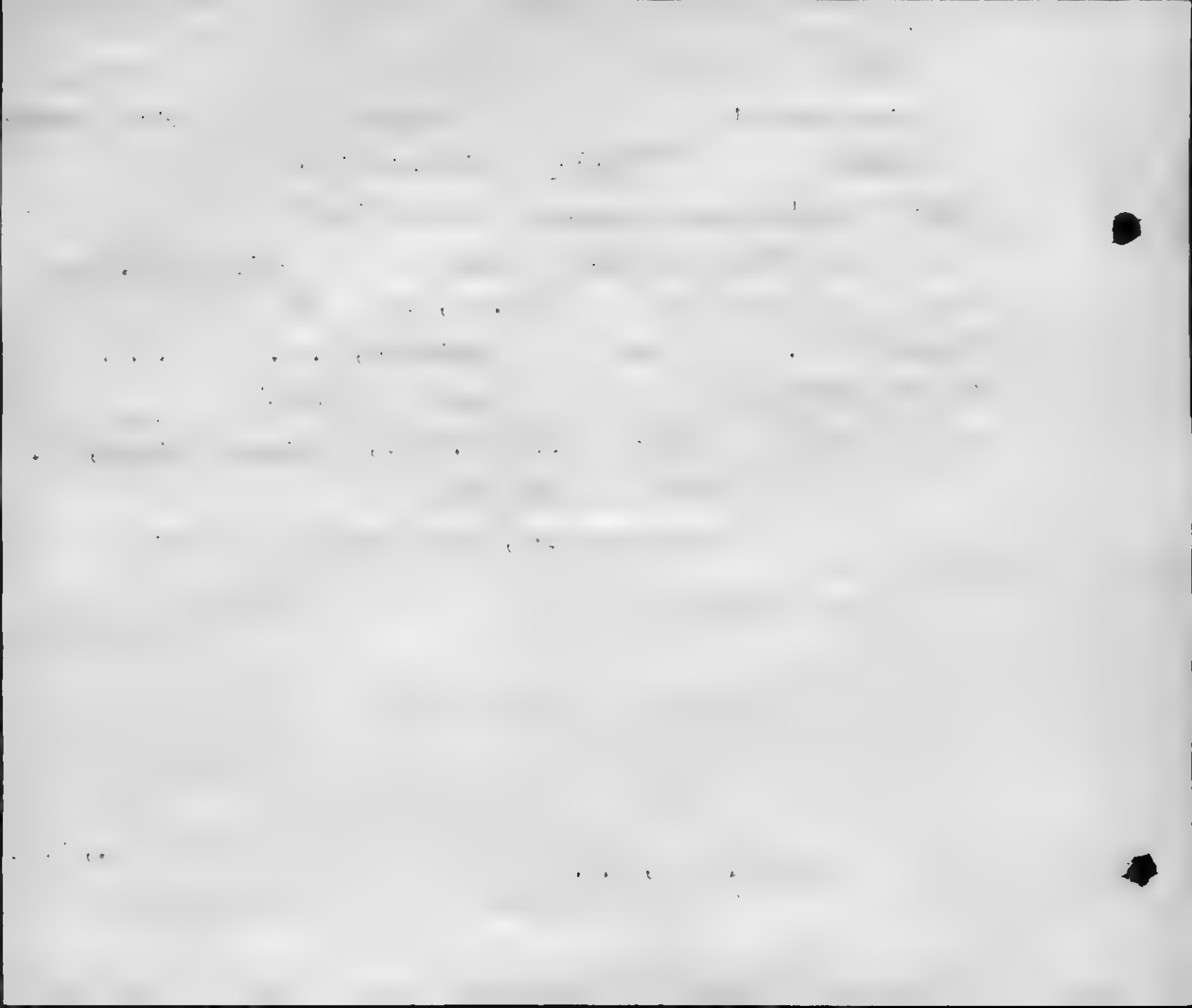
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence, before admission on)			
a. COUNTY				a. STATE			
Prince George's				Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cheverly				Fairmont Heights			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
Prince George's General Hospital				603 60th Place			
3. NAME OF DECEASED				4. DATE OF DEATH			
(Type or print)				Month Day Year			
Sarah Frances Nash				July 19th, 1961			
5. SEX				6. COLOR OR RACE			
Female				Colored			
7. MARRIED				8. DATE OF BIRTH			
<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				Nov. 10, 1888			
9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
72 yrs.				Housewife Ret.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Washington, D. C.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Hilliary Jackson				Sarah (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
None				None			
17. INFORMANT				Address			
Frank H. Nash,				603 60th Place, Fairmont Heights, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia and exhaustion</u>							
DUE TO							
(b) <u>Lobar pneumonia, lung abscess and empyema</u>							
DUE TO							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE				CHIEF MEDICAL EXAMINER			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER			
JAMES I. BOYD, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED				Address (Street, city, town, or county)			
July 19th., 1961				22a. BURIAL, CREMATION, REMOVAL (Specify)			
Burial				22b. DATE THEREOF			
7/24/61				22c. NAME OF CEMETERY OR CREMATORY			
NAT. HARMONY				22d. LOCATION (City, town, or country) (State)			
PRINCE GEORGES				23. FUNERAL DIRECTOR			
John T. Rhinehart & Co.				24. REC'D BY REGISTRAR			
3015-12 Street N.E. Washington D.C.				24b. REGISTRAR'S SIGNATURE			
DATE JUL 25 '61				Arthur S. Hanna			

08265



8372

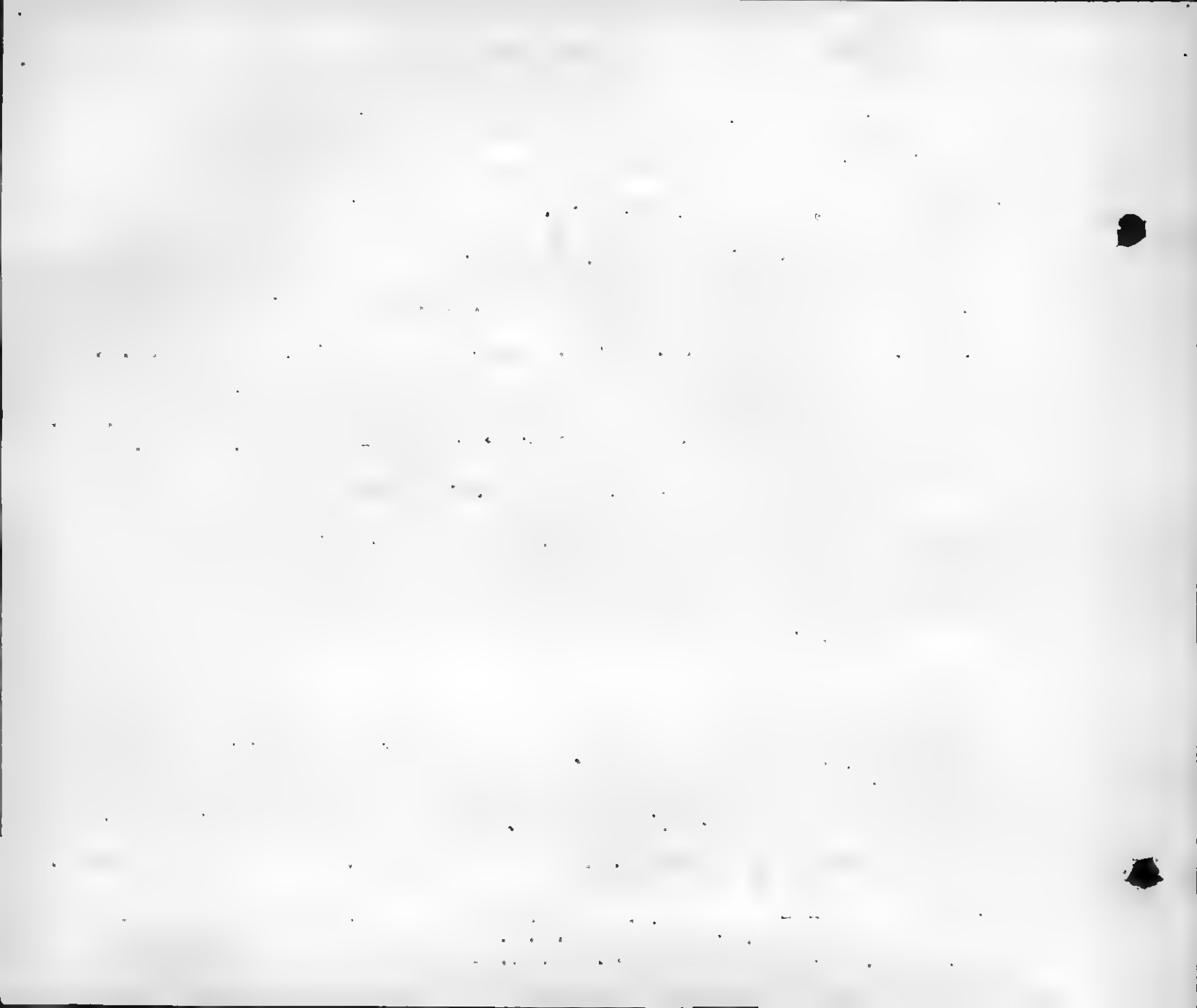
CERTIFICATE OF DEATH

Reg. Dist. No. 38366

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>NEW JERSEY</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MAJOR, 4922 La SALLE, RD.</u>		e. STREET ADDRESS <u>ALTERNATE HOTEL</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET L. O'BRIEN</u>		4. DATE OF DEATH Month Day Year <u>JULY 30, 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1877</u>
9. AGE (In years last birthday) yrs. <u>83</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORGAN O'BRIEN</u>		14. MOTHER'S MAIDEN NAME <u>----</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
INFORMANT <u>SISTER PATRICK-4922 LaSalle Rd.</u>		Address <u>HYATTS. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/27</u> 19 <u>61</u> , to <u>7/30</u> 19 <u>61</u> , that I last saw the deceased alive on <u>7/27</u> 19 <u>61</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Steven Oristian</u> M.D.		DATE SIGNED <u>1534 16th St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>STEVEN ORISTIAN, M.D.</u>		<u>1534 16th St. N.W. WASH. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-1-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>IN. OLIVER CEM. GRY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>FRANCIS J. COLLINS</u>		ADDRESS <u>WASH. D.C.</u> <u>14th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>AUG 2 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kneel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8373

CERTIFICATE OF DEATH

08367

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VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 1101 Montgomery St.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN TB 3 yrs. 9 da.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel Sanitarium				4. DATE OF DEATH July 30 1961			
3. NAME OF DECEASED (Type or print) Martha Mary O'Brien				5. SEX Female 6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 23, 1868				9. AGE (In years, last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. PLACE OF BIRTH Prince George's, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edwin Sullivan				14. MOTHER'S MAIDEN NAME Mary A. Barnett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Son - J.W. O'Brien - 1101 Montgomery				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Biliary Obstruction 151X DUE TO Carcinoma of Pancreas				INTERVAL BETWEEN ONSET AND DEATH 4 days many mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerotic Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25-58 to 7-30-61, that (I) (we) last saw the deceased alive on 7-29-61, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Jesse C. Coggins M.D.				22b. DATE SIGNED 7-30-61			
22c. PHYSICIAN'S NAME (Type) Jesse C. Coggins				22d. ADDRESS Laurel Sanitarium			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Aug 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cem		23d. LOCATION (City, town or county) (State) Laurel Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR DATE AUG 4 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

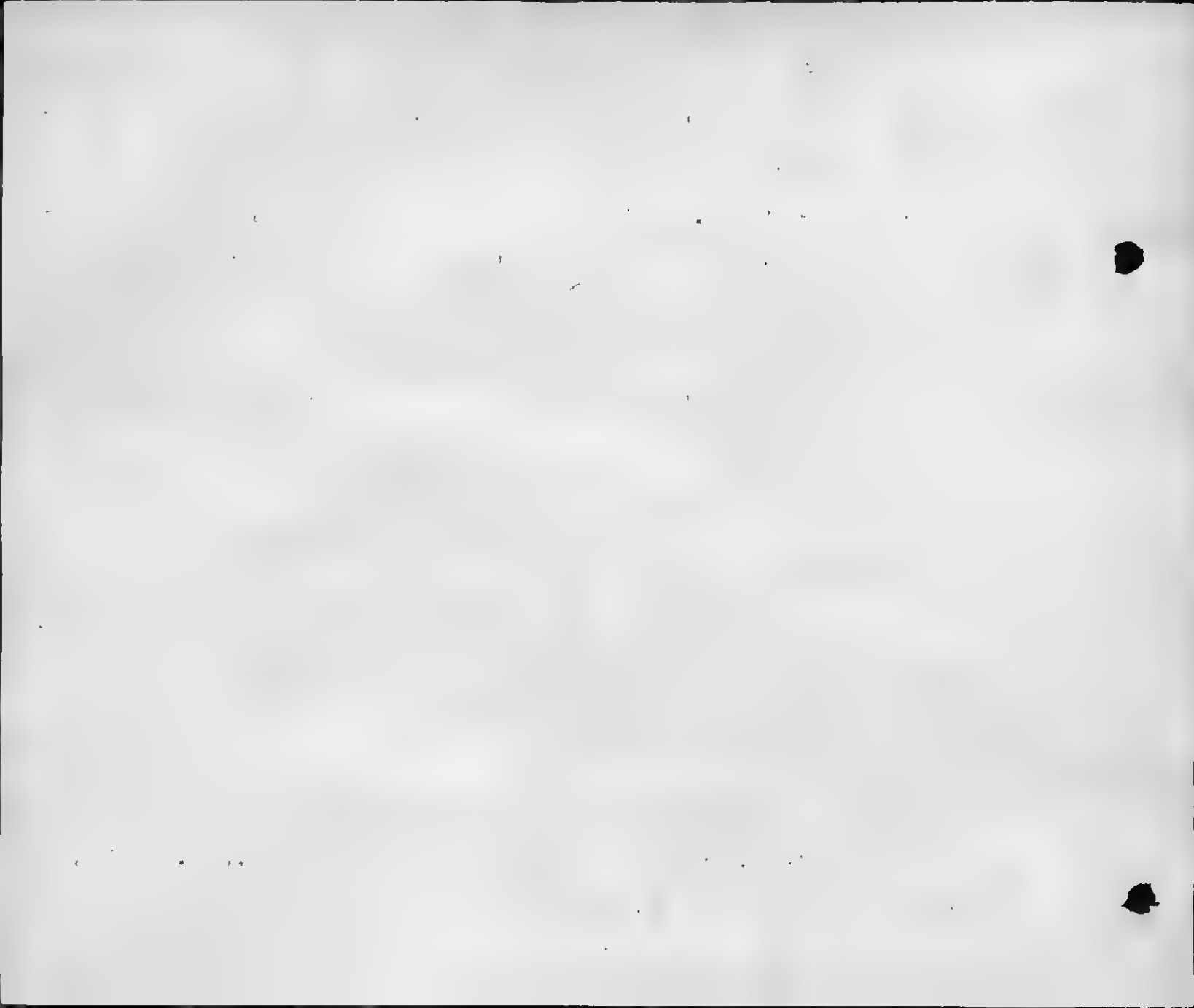
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8374

88363

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carrollton</u>	
c. LENGTH OF STAY IN b. <u></u>		d. STREET ADDRESS <u>8400 Sprague Pl.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maureen</u> Middle <u>Jane</u> Last <u>O'Connor</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Month <u>July</u> Day <u>23</u> Year <u>1961</u>		9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Joseph O'Connor</u>		14. MOTHER'S MAIDEN NAME <u>Maureen Jane Maguire</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>None</u>		17. INFORMANT <u>Mother</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.N.S. Compression</u> DUE TO (b) <u>Hydrocephalus (DEVELOPMENTAL)</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Greco</u>		22b. DATE SIGNED <u>7/23/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Greco</u>		ATTEND NG PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <u>3303 Perry St., Mt. Rainier, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town or county) <u>Washington D.C.</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>JUL 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



DO NOT SIGN **MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CHIEF MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02363

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs c. LENGTH OF STAY IN IC (9 years) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5100 Ludlow Road Drive		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs d. STREET ADDRESS 5100 Ludlow Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sophie Theresa Paolo 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.		4. DATE OF DEATH Month Day Year July 24 1961 9. AGE (In years less birthday) yrs 10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Hitzcynke 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. No 14. MOTHER'S MAIDEN NAME Martyneck 17. INFORMANT Address Matthew Paolo, same as no 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POISONING 971.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) NICOTINE SULFATE (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took some black leaf 40 20c. TIME OF INJURY Month, Day, Year 7:50 P.M. 7/24/1961 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Camp Springs (County) P.G. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/24/61 James I. Boyd James I. Boyd 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-28-1961 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln 22d. LOCATION (City, town, or country) (State) Prince Georges Co Md 23. FUNERAL DIRECTOR Robert A. Mattingly 131-11488 24a. REC'D BY REGISTRAR JUL 26 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

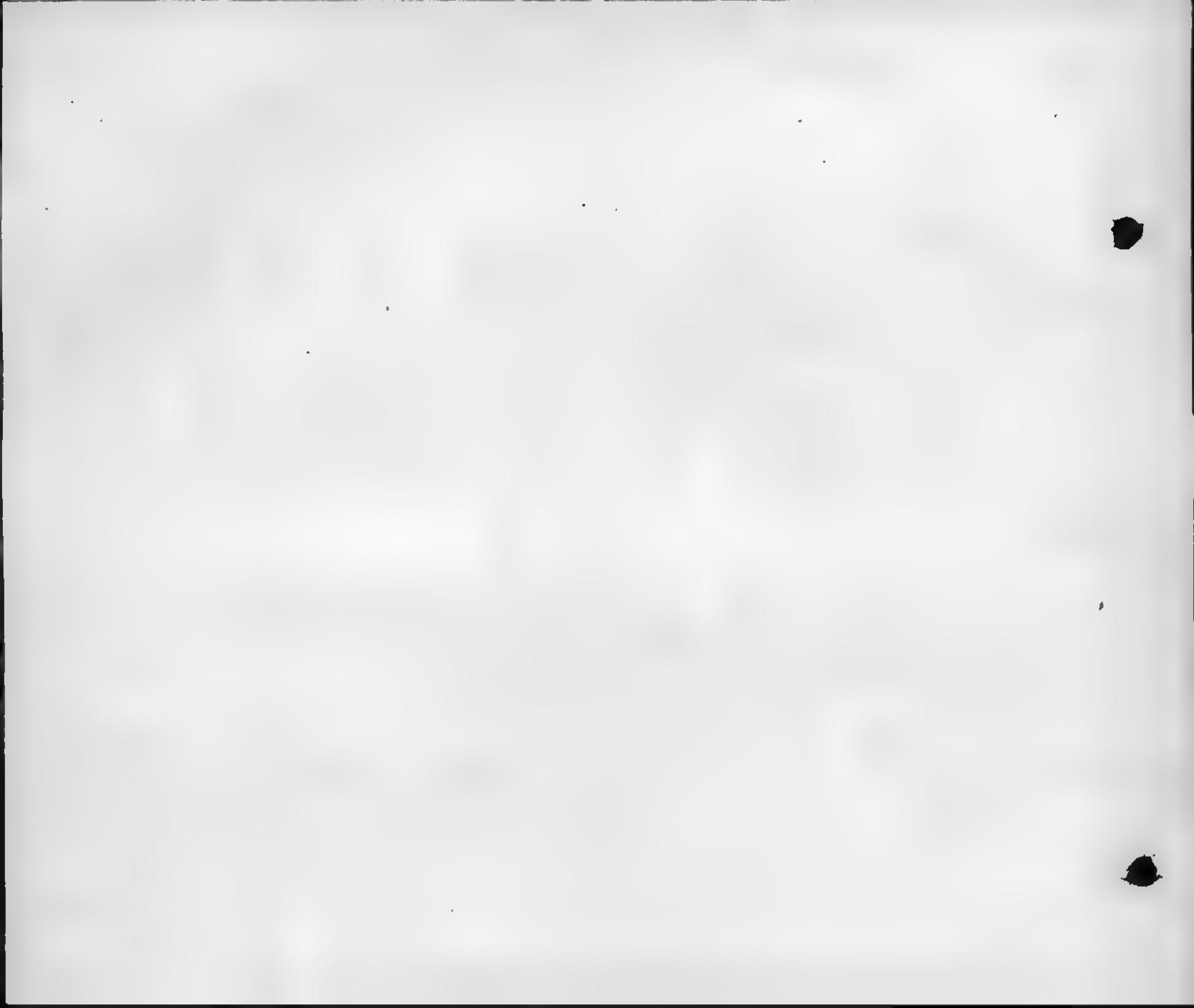


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8376

08370

1 PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <i>MINNESOTA</i> b. COUNTY <i>Hennepin</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SUITLAND</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Minneapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUITLAND Nursing Home</i>		d. STREET ADDRESS <i>515-9th Ave. S.E.</i>	
3 NAME OF DECEASED (Type or print) <i>Lucy F. Pemberton</i>		4 DATE OF DEATH <i>July 9 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-1880</i>
9 AGE (In years last birthday) <i>80</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11 BIRTHPLACE (State or foreign country) <i>MINNESOTA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>JERRY FINNEY</i>		14. MOTHER'S MAIDEN NAME <i>MARY ANN Plummer</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16 SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Virginia P. Norgarden</i>		Address <i>166- Chesapeake ST Wash DC SW</i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>425.0 Congestive Heart Failure</i> DUE TO (b) <i>Right Hemiparesis</i> DUE TO (c) <i>Arterio-sclerotic Heart Disease + Cerebral A.S.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 days</i> <i>15 days</i> <i>1 year</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>August 16, 1960</i> to <i>July 9, 1961</i> , that (I) (we) last saw the deceased alive on <i>6/30 1961</i> , and that death occurred at <i>7/9/61</i> M, from the causes and on the date stated above.			
22a SIGNATURE <i>Anna Coyne Todd, M.D.</i>		22b. DATE SIGNED <i>7/9/61</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>7519 Broadview Rd S.E.</i>	
23a BURIAL CREMATION, 23b DATE THEREOF <i>Buried 7-11-61</i>		23c NAME OF CEMETERY OR CREMATORY <i>Lakewood Cemetery Minneapolis Minn.</i>	
23d LOCATION (City, town, or county) (State)		25a REC'D BY REGISTRAR <i>1661- Good Hope Rd SE WASH. 20 DC</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i>		25b REGISTRAR'S SIGNATURE <i>Arthur J. Kneass</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8377									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 21 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1000 MISSISSIPPI AVENUE SE d. STREET ADDRESS 47X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) RHONDA LYNN PEREZ					4. DATE OF DEATH Month JULY Day 24 Year 19 61				
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 JULY 1961		9. AGE (In years last birthday) yrs. 21 Months 21 Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY UNITED STATES	
13. FATHER'S NAME RAUL PEREZ					14. MOTHER'S MAIDEN NAME BRENDA KAY FANN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEDICAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA, EMPYEMA, PERITONITIS (c) TRACHEO-ESOPHAGEAL FISTULA REPAIR								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURITY								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
21. I certify that he (this hospital) attended the deceased from 3 JULY 1961 , to 24 JULY 1961 , that he (we) last saw the deceased alive on 24 JULY 1961 , and that death occurred at 6: P M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Edward G. Dowds</i> M.D.					22b. DATE SIGNED 24 JULY 61		22c. PHYSICIAN'S NAME (Type) EDWARD G. DOWDS, Captain USAF MC		
22d. ADDRESS USAF HOSPITAL, ANDREWS AFB, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/29/61		23c. NAME OF CEMETERY OR CREMATORY ERWIN CEMETERY		23d. LOCATION (City, town or county) (State) DUNN NORTH CAROLINA			
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. 517-11th St SE, Wash D.C.</i>					25a. REC'D BY REGISTRAR DATE JUL 28 '61		25b. REGISTRAR'S SIGNATURE <i>Carlton L. Thomas</i>		

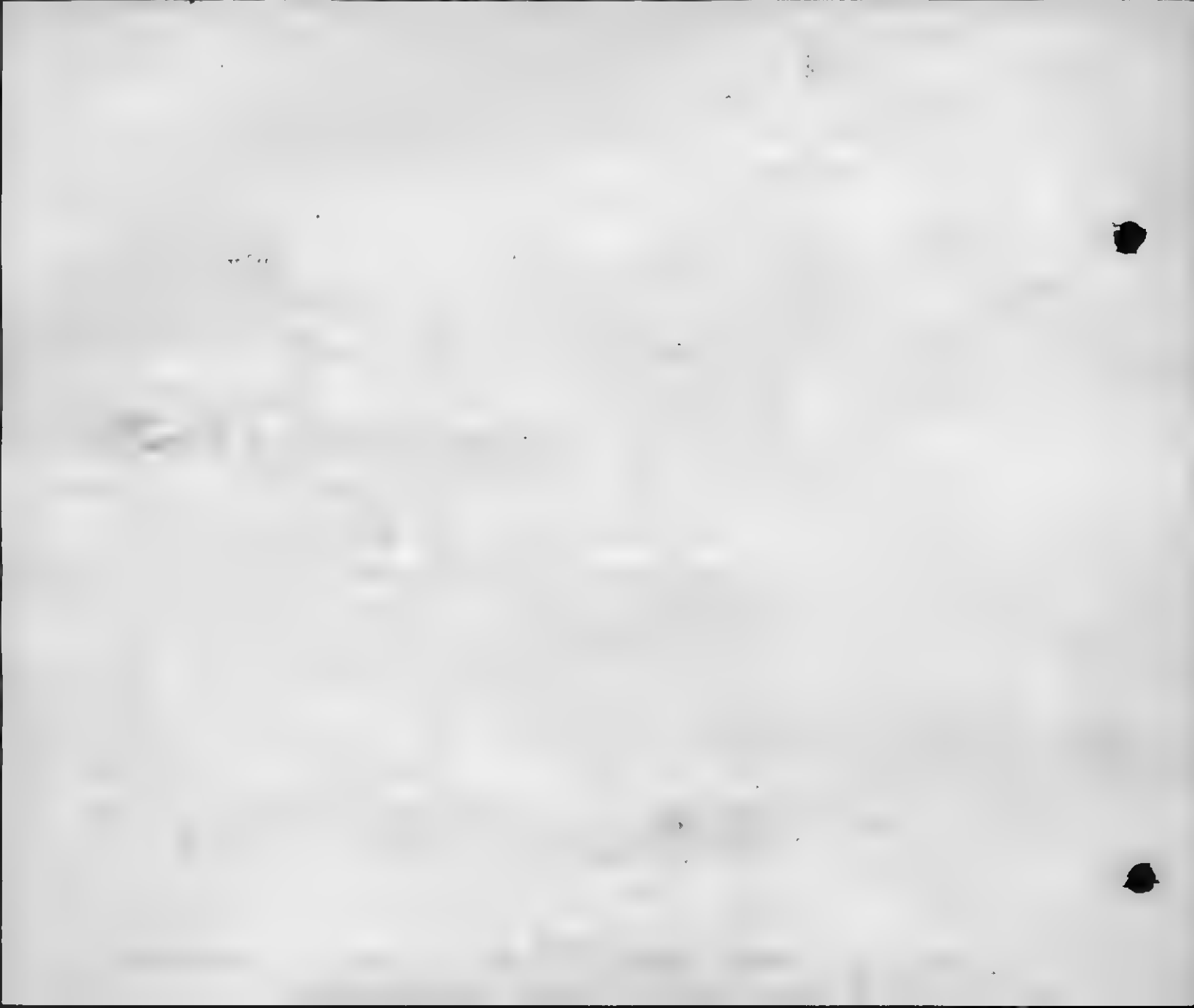


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
8378													
Item 7 from 3200 7/10/61 ink													
8372													
1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights				b. COUNTY Prince George									
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS 5312 29th st. Ave									
3. NAME OF DECEASED (Type or print) First Middle Last Mary Bessie Pixton				4. DATE OF DEATH Month Day Year July 3 1961									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George H Reidy				14. MOTHER'S MAIDEN NAME Lucille Buckler									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. None				17. INFORMANT Alice CANTERBURY Hillcrest Heights Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Acute cardiac insufficiency (c) Carcinoma of colon with extensive Metastases.				INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10:19 to 7:30, 1961, that (I) (we) last saw the deceased alive on 6-28-1961, and that death occurred at 12:00 M, from the causes and on the date stated above.													
22a. SIGNATURE Peter Duus				M.D.				22b. DATE SIGNED 7-3-61					
22c. PHYSICIAN'S NAME (Type) PETER DUUS				22d. ADDRESS 6124 Central Av									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 7-6-61				23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETARY				23d. LOCATION (City, town or county) (State) Capitol Heights Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons				ADDRESS 300 Hth St N.E.				25a. REC'D BY REGISTRAR DATE JUL 5 '61				25b. REGISTRAR'S SIGNATURE William S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8379

08373

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 10 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>Pratt Jr</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Oct 59</u>	
9. AGE (in years lost birthday) yrs <u>1</u>		IF UNDER 1 YEAR Months <u>20</u> Days <u></u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Honolulu Hawaii</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William C. Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Briggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go on for unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Hospital Chart</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>							<u>2 hours</u>
754.3 DUE TO <u>INTRAVENTRICULAR SEPTAL DEFECT</u>							<u>20 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>congenital Heart Disease</u>							<u>20 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hydrocephalus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from <u>21 July, 1961</u> , to <u>21 July, 1961</u> , that (we) last saw the deceased alive on <u>21 July, 1961</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Nicholas P. Haritos</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>21 JULY 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>NICHOLAS P HARITOS, Captain USAF MC</u>				22d. ADDRESS <u>USAF HOSPITAL, ANDREWS AFB, MD</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>24 July 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARlington</u>		23d. LOCATION (City, town, or county) (State) <u>ARlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Funerary Home</u>				25a. REC'D BY REGISTRAR <u>816-H-816</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	
DATE <u>JUL 24 '61</u>				DATE <u>JUL 24 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8380

00374

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1422 N. St., N.W.	
3. NAME OF DECEASED (Type or print) Robert L. Price		4. DATE OF DEATH Month 7 Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> but separated (not legally)	8. DATE OF BIRTH 5/29/03
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY John Tester & Son N.C. Washington, D.C.	
11. PLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James M. Price		14. MOTHER'S MAIDEN NAME Esther Duckett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 579-45-2136	
17. INFORMANT Decedent		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Carcinoma of the anus with metastases**

190.5 } DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Abdominal perineal resection, 12/60; right transverse colostomy, 12/60; groin infection secondary to carcinomatous invasion of lymph nodes; **

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year 10/19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 10:05	(County) 7/27/	(State) 1961
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21. I certify that (I) (this hospital) attended the deceased from **10/19** to **7/27/**, 19**61**, that (I) (we) last saw the deceased alive on **7/27**, 19**61**, and that death occurred at **10:05** M., from the causes and on the date stated above.

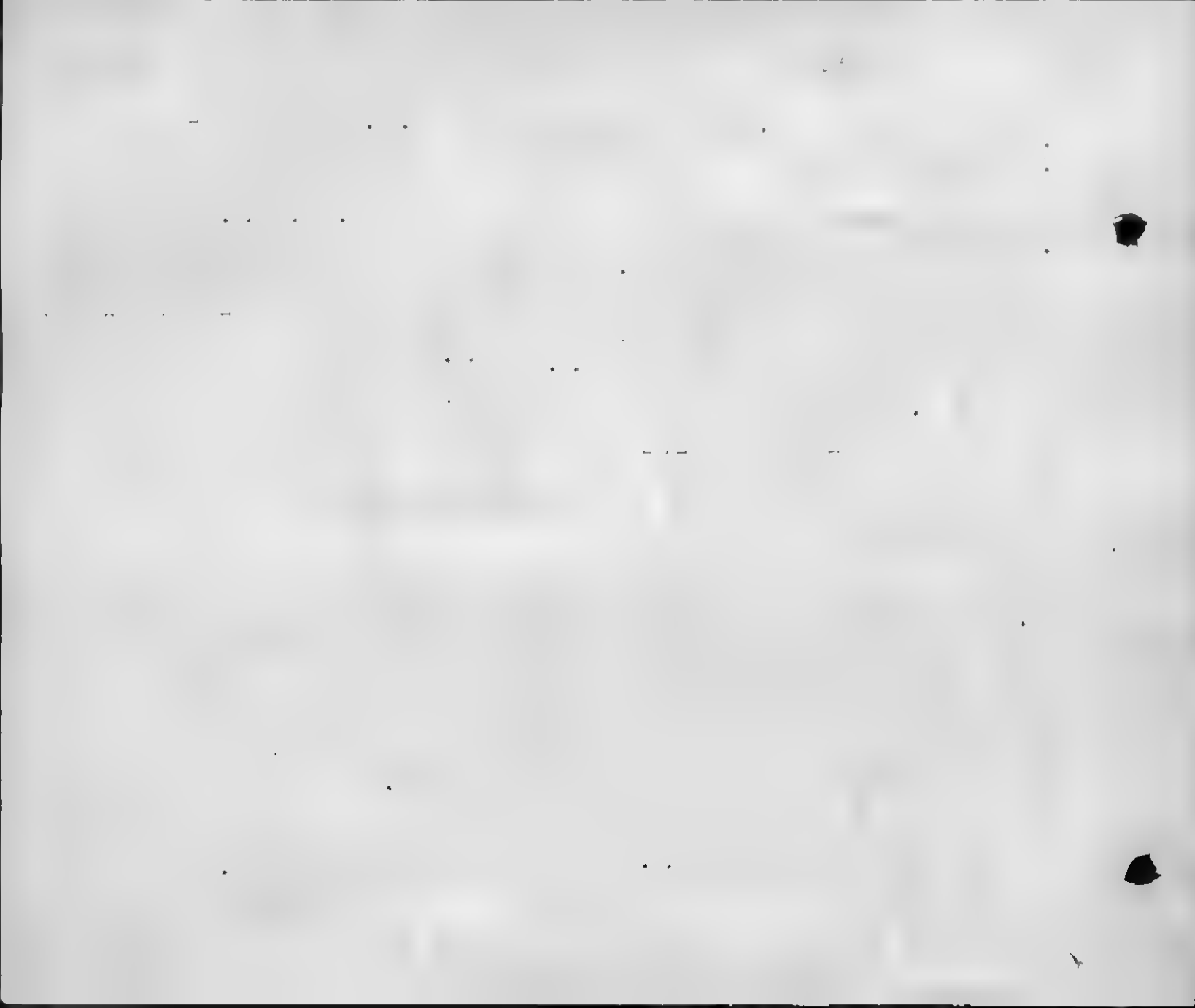
22a. SIGNATURE Moe Weiss	22b. DATE SIGNED 7/27/61
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.	22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-31-61	23c. NAME OF CEMETERY OR CREMATORY Eden Hill	23d. LOCATION (City, town or county) Suitland Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee		25a. REC'D BY REGISTRAR Aug 2 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

** pulmonary tuberculosis, far advanced, active (2 yrs. 7 mos.), (Chemotherapy) died

MEDICAL CERTIFICATION



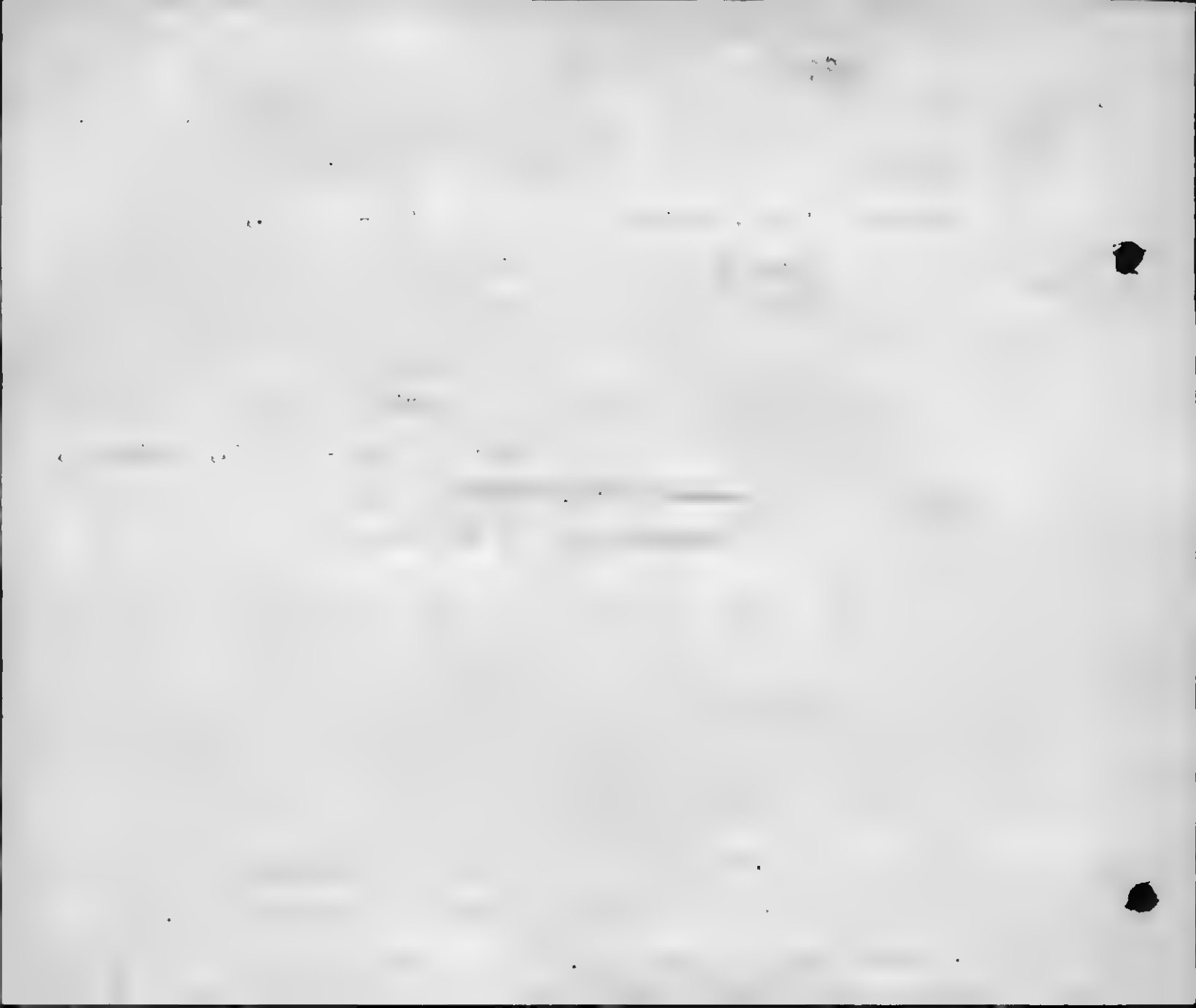
Item 18 Film 306 2/8/61 2-8-61
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8381

08375

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hospital		e. STREET ADDRESS 5705 - 40th Pl.,	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Last Priest Month July Day 8 Year 19 61	
5. SEX Male		6. CO. OR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 8 1961	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Lee Priest		14. MOTHER'S MAIDEN NAME Gloria Ann Everidge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Mother		Address 5705 - 40th Pl., Hyattsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Deferred for microscopy 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Atelectasis of the lungs (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Month, Day, Year Hour 1:40 p.m. 8 July 1961		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 8, 1961 to July 8, 1961 , that (I) (we) last saw the deceased alive on July 8, 1961 , and that death occurred at 1:40 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Gordon W. Kelley M.D.		22b. DATE SIGNED July 8 1961	
22c. PHYSICIAN'S NAME (Type) Gordon W. Kelley		22d. ADDRESS 6129 - 41st Ave. Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. Gasch's Sons		25a. REC'D BY REGISTRAR JUL 13 '61	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

X

I

3382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08376

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7309 23rd Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eugenie First Middle Last				4. DATE OF DEATH July 18 1961 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 March 1885	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Canada	
13. FATHER'S NAME Stanislaus Rolin				14. MOTHER'S MAIDEN NAME Victoria Canuelle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lorraine Q. Cecil Same as # 2 Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 200.1 DUE TO Lymphosarcoma, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7:00-1 to 3:58 on July 17, 1961 that (I) last saw the deceased alive on July 17, 1961 , and that death occurred at 3:58 M, from the causes and on the date stated above.							
22a. SIGNATURE Richard L. Whelton				22b. DATE 7-18-61			
22c. PHYSICIAN'S NAME (Type) RICHARD L. WHELTON				22d. ADDRESS 1021 University Blvd E. Silver Spring			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal Burial		7/21/61		Sacaret Heart Cemetery Andover		Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REG-STRAR DATE JUL 20 '61			
ADDRESS Hyattsville, Md.				25b. REGISTRAR'S SIGNATURE Richard L. Whelton			



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8383 CERTIFICATE OF DEATH 02377

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4th & Lincoln Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Reddick				4. DATE OF DEATH Month Day Year July 1 19 61			
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 July 1961		9. AGE (In years last birthday) yrs 1	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Reddick				14. MOTHER'S MAIDEN NAME Rose Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1961, to July 1, 1961, that (I) (we) last saw the deceased alive on July 1, 1961, and that death occurred at 10330PM from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) John W. Perkins, M.D.	
22d. ADDRESS 5301 Hamilton St., Hyattsville, Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hospital		23d. LOCATION (City, town, or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

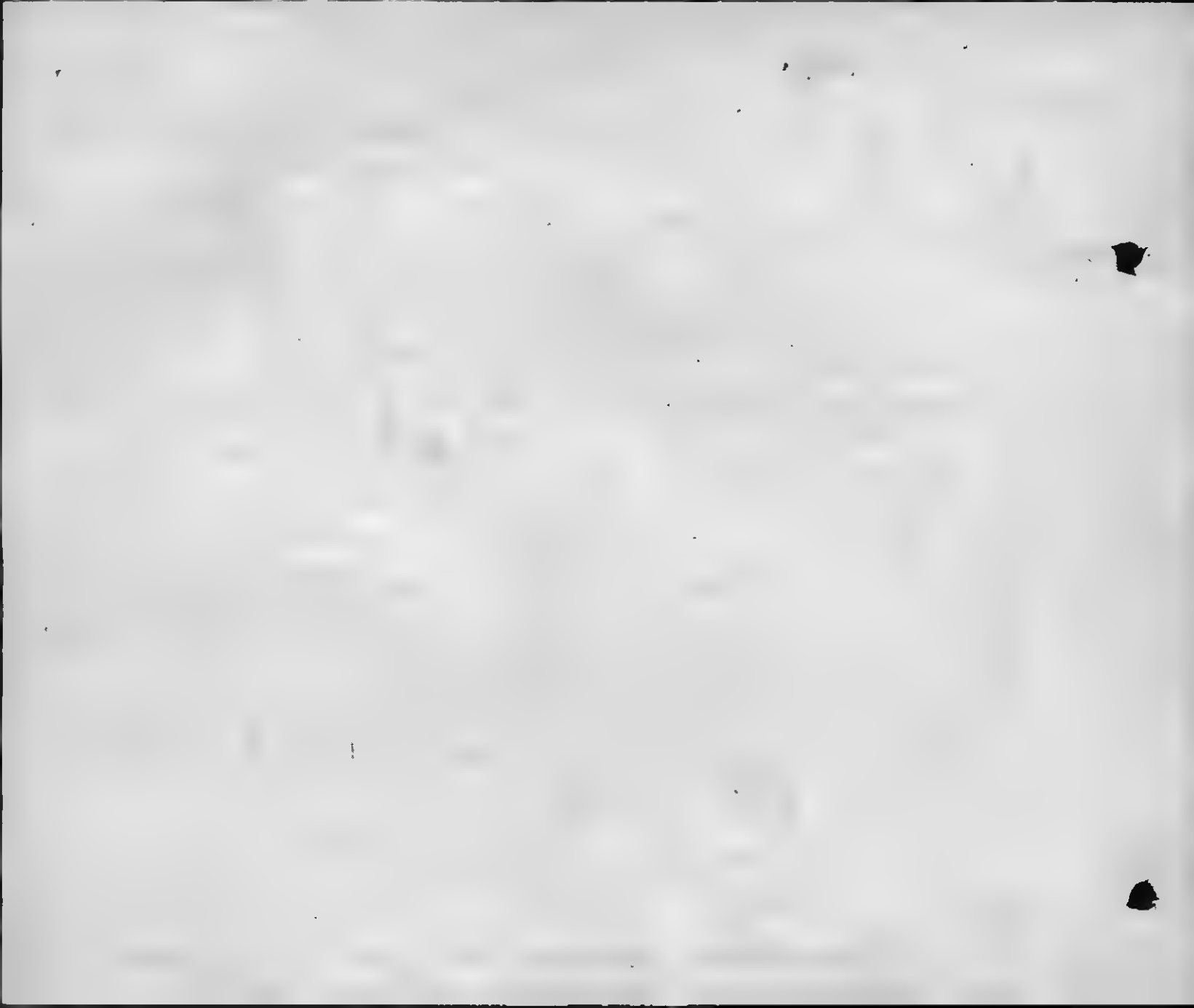
8384

CERTIFICATE OF DEATH

08378

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN It <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>5356 - Quincy Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>WILLIAM M. RHODES</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>14</u> , Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman - Retired Suburban Comm.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington</u>				11. BIRTHPLACE County & State, or foreign country <u>Fayette Co. Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Henry L. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Dora J. Sturgis</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give word or service) <u>no</u>				16. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT Address <u>above</u> <u>Little R. V. Rhodes</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u> cause last.												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER.)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 14, 1960</u> to <u>July 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 14, 1961</u> , and that death occurred at <u>9:51 AM</u> , from the cause and on the date stated above.															
22a. SIGNATURE <u>William D. Rosson M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>William D. Rosson</u>				22d. ADDRESS <u>5701 - 85th Ave. Carrollton Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus</u>				23d. LOCATION (City, town or county) (State) <u>Md.</u> <u>Damascus, Frederick Co.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>				ADDRESS <u>147 Rainier Dr. George, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>					



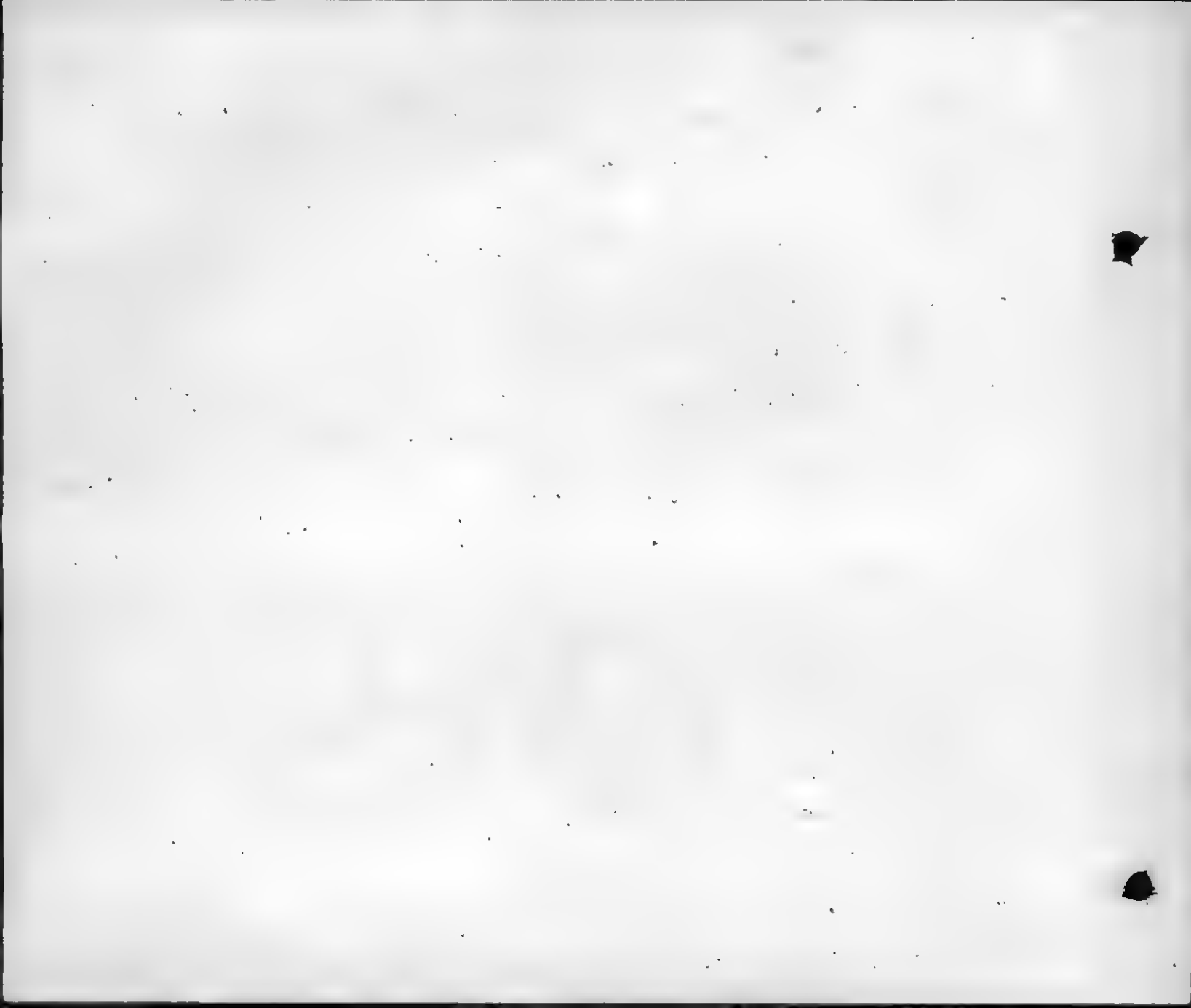
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8385

CERTIFICATE OF DEATH

Reg. Dist. No. 83379

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4200-70th Avenue</i>		d. STREET ADDRESS <i>4200-70th Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>M. Richtarsic</i> Last <i></i>		4. DATE OF DEATH Month <i>July</i> Day <i>14th</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/7, 1895</i>
9. AGE (In years last birthday) <i>65</i> yrs		10. IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nursing</i>	
11. BIRTHPLACE (State or foreign country) <i>Crenshaw, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Louis M. Richtarsic</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Chernisky</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>263-16-1612</i>	
17. INFORMANT <i>Mrs. Robert Murphy</i>		Address <i>4200-70th Ave Landover Hills, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition & Cachexia</i> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized abdominal metastases</i> DUE TO (c) <i>Carcinoma of the Cervix</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i> <i>1 yr.</i> <i>30 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1 May, 1961</i> to <i>14 Jul, 1961</i> , that I last saw the deceased alive on <i>14 Jul, 1961</i> , and that death occurred at <i>10:05 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas G. Madoney</i> M.D.		ADDRESS (Street, city or town, state) <i>4814-71st Ave. 14 Jul 61</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS G. MADONEY</i>		— <i>LANDOVER HILLS MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/18/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Tobias Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Brockway Jefferson Co., Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home</i> ADDRESS <i>14th Rainier</i>		24a. REC'D BY REGISTRAR <i></i> 24b. REGISTRAR'S SIGNATURE <i></i>	
DATE <i>Jul 18 '61</i>		<i></i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

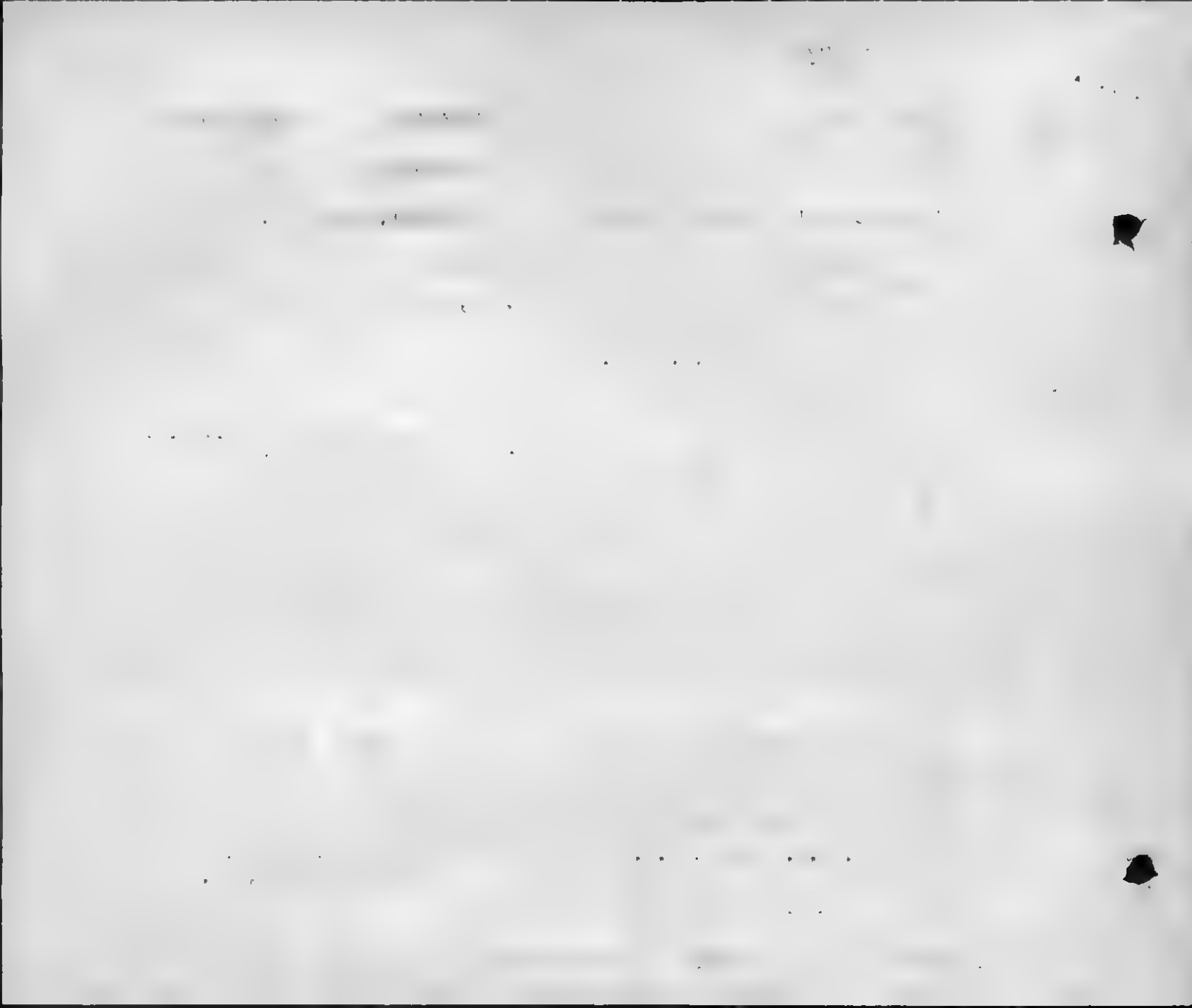
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8386

08380

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>3 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Rockingham</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrisonburg</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucie M Robertson</u> 5 SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr. 23, 1886</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Auditor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> 11. BIRTH-PLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Armentrout</u> 14. MOTHER'S MAIDEN NAME <u>Cornelia Bare</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO _____ 17. INFORMANT <u>Roy R. Robertson</u> Address <u>5321-Que St., S.E. Wash. 27, DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>350</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) <u>Parkinson Disease</u> (c) _____ DUE TO _____ cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____ 1961 to <u>July 8</u> , 1961 , that (I) (we) last saw the deceased alive on _____ 1961 , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. B.S. Pecson</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. B.S. Pecson, M.D.</u>		22b. DATE SIGNED <u>7-8-61</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7028 Marlboro Pike, District Heights, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-7-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION (City, town or County) <u>Roanoke, Virginia</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROTHERS</u> ADDRESS <u>1661-GOOD HOPE RD, S.E.</u>		25a. REC'D BY REGISTRAR _____ 25b. REGISTRAR'S SIGNATURE <u>Carling S. Knead</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

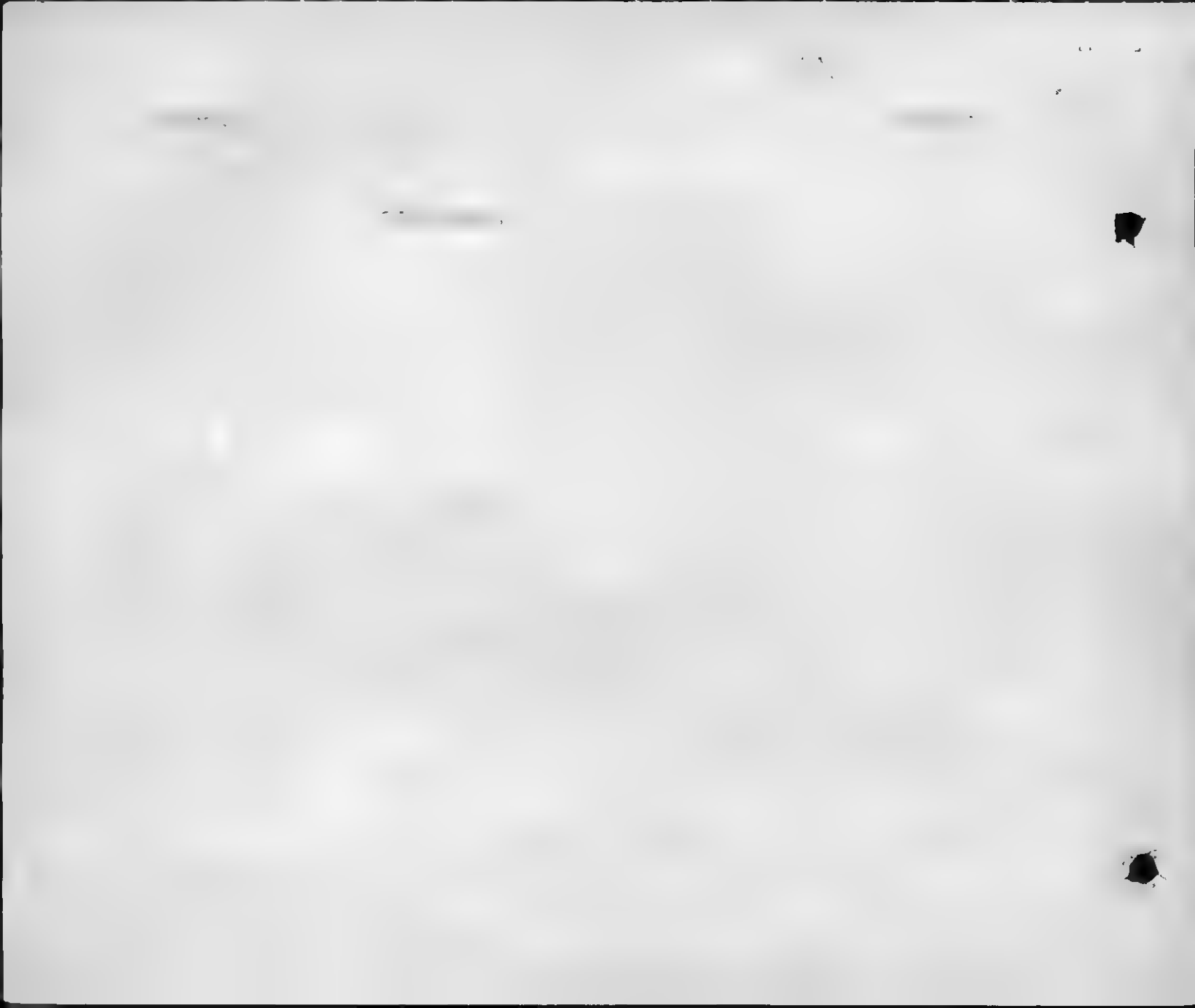
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8387

00381

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN 1b <u>CLINTON</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. WALDORF</u> d. STREET ADDRESS <u>W. WALDORF</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH E. ROBEY</u>		4. DATE OF DEATH Month Day Year <u>JULY 9 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-89</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. AGE (In years last birthday) <u>72</u> yrs.	11. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Lyon</u>		14. MOTHER'S MAIDEN NAME <u>Francis E. Robey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>PAUL ROBEY, WALDORF, MD.</u>	
17. INFORMANT <u>PAUL ROBEY, WALDORF, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pyelonephritis</u> DUE TO (b) <u>CVA (cerebral thrombosis)</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>16 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>General Debility</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6/22</u>		20f. (City or town) (County) (State) <u>7/9/61</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> <u>1961</u> to <u>7/9/61</u> that (I) (we) last saw the deceased alive on <u>7/9/61</u> and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lepore M.D.</u>		22b. DATE SIGNED <u>7/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred R. Lepore</u>		22d. ADDRESS <u>W. WALDORF</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>17-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Rest</u>		23d. LOCATION (City, town or county) (State) <u>LA PLATA, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8388

CERTIFICATE OF DEATH

08382

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. 8 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood d. STREET ADDRESS 4004 38th St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MADELYN M. 4. DATE OF DEATH July 22 1961 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 21, 1999 9. AGE (In years last birthday) 61 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife from home 10b. KIND OF BUSINESS OR INDUSTRY New Haven, Conn. 11. BIRTHPLACE (Country & State or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Bernard Lynch 14. MOTHER'S MAIDEN NAME unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. Joseph Bernard Roche 17. INFORMANT above Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. hepatic failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Portal Cirrhosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (i) (this hospital) attended the deceased from June 1961 to July 22 1961 , that (ii) (we) last saw the deceased alive on 7/22 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. 22a. SIGNATURE Leon Levitsky 22b. DATE SIGNED 7/22/61 22c. PHYSICIAN'S NAME (Type) Dr. Leon Levitsky, M.D. 22d. ADDRESS 3408 Chode St. NE, 2nd Floor, NE 22e. REC'D BY REGISTRAR AUL 24 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Hanna			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July 25/61 23c. NAME OF CEMETERY OR CREMATORY St. Bernards 23d. LOCATION (City, town or county) (State) New Haven, Conn.			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc. 25. ADDRESS ext. Rainer			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8389

00383

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood Md				c. LENGTH OF STAY IN 1b 56 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3800 Taylor Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Sampson				4. DATE OF DEATH Month Day Year July 14, 19 61			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 19, 1873	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Sampson				14. MOTHER'S MAIDEN NAME Georgeanna Drake			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. none		17 INFORMANT Lucy Sampson		Address Brentwood, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serility							INTERVAL BETWEEN ONSET AND DEATH 24 hrs 17 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 9-19-1944 to 7-14-1961 , that (I) (we) last saw the deceased alive on 7-14-1961 , and that death occurred at 11:PM , from the causes and on the date stated above							
22a. SIGNATURE Waldo B. Moyers				22b. DATE SIGNED 7-14-61			
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers				22d. ADDRESS 3503 Pelery St. Mt. Rainier Md.			
23a. BURIAL, CREMATION, OR MOVEMENT (Specify) Burial		23b. DATE THEREOF 7/18/61		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DATE JUL 19 '61	
				25b REGISTRAR'S SIGNATURE Conrad S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

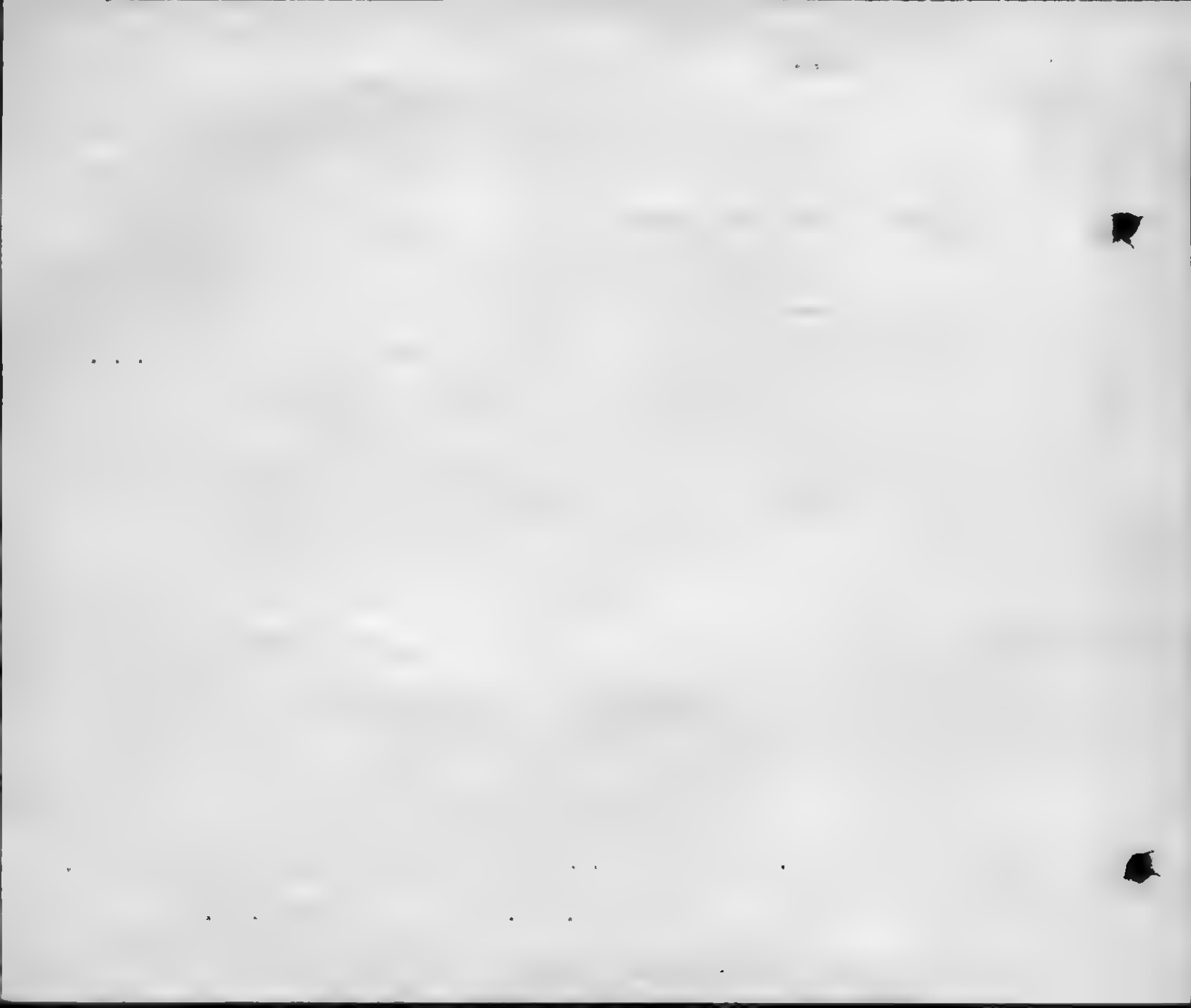
8390

CERTIFICATE OF DEATH

08384

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly 2 hr		c. LENGTH OF STAY IN 1b Aquasco	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Savoy		4. DATE OF DEATH Month 11 Day July Year 1961	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 July 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (in years last birthday) 11 MONTHS 2 DAYS 2 HRS. 2	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME William Lorraine Savoy		14. MOTHER'S MAIDEN NAME Mary Alice Chapman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Mary Alice Chapman Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11 July 1961 to 11 July 1961 that (I) (we) last saw the deceased alive on 11 July 1961 and that death occurred at 6:30A from the causes and on the date stated above.			
22a. SIGNATURE T. A. Christensen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D.		22d. ADDRESS 6905 Baltimore Ave., College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/22/61	
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City, town or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn Jr.		25a. REC'D BY REGISTRAR JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Thomas			

Harry W. Penn Jr., Administrator



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

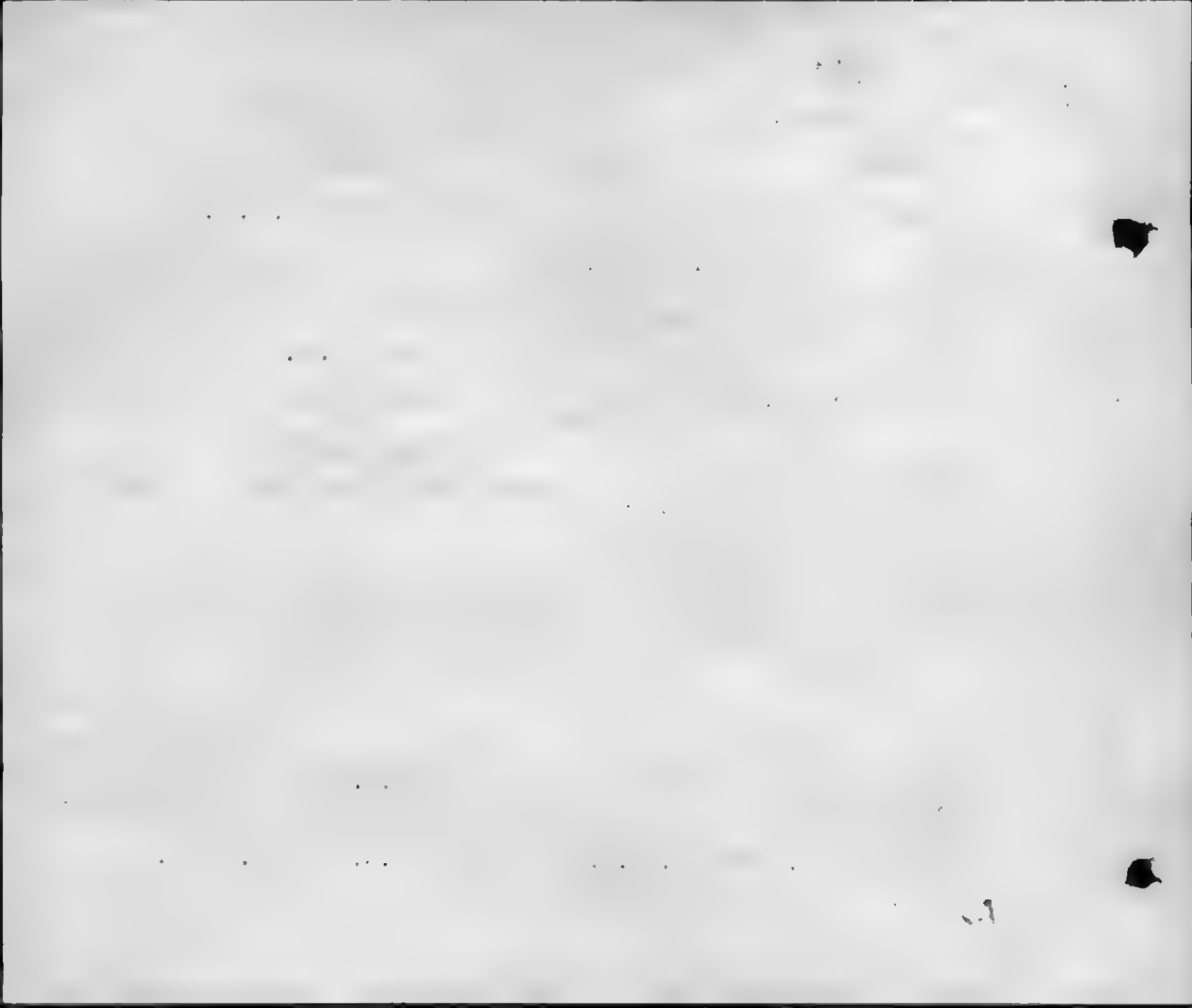
CERTIFICATE OF DEATH

8391

03885

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 8 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4620 Windham Pl., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie T. Schubert		4. DATE OF DEATH Month July Day 14th Year 1961		5. SEX Female 6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4th 1876		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalid		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Martin Schubert		14. MOTHER'S MAIDEN NAME Barbara Bernstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Sacred Heart Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis with Myocardial Infarction (b) Arteriosclerotic Heart Disease (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town		20g. (County)		20h. (State)	
21. I certify that (I) (the undersigned) attended the deceased from 6/30/1961 to 7/14/1961 , that (I) XX saw the deceased alive on 7/13/1961 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Collins		22b. DATE SIGNED 7/14/1961		22c. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.	
22d. ADDRESS 322-H. St. N.E. Wash. 2, D.C.		23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial July 17-1961			
23b. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23c. LOCATION (City, town or County) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Costello		25a. REC'D BY REGISTRAR DATE JUL 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

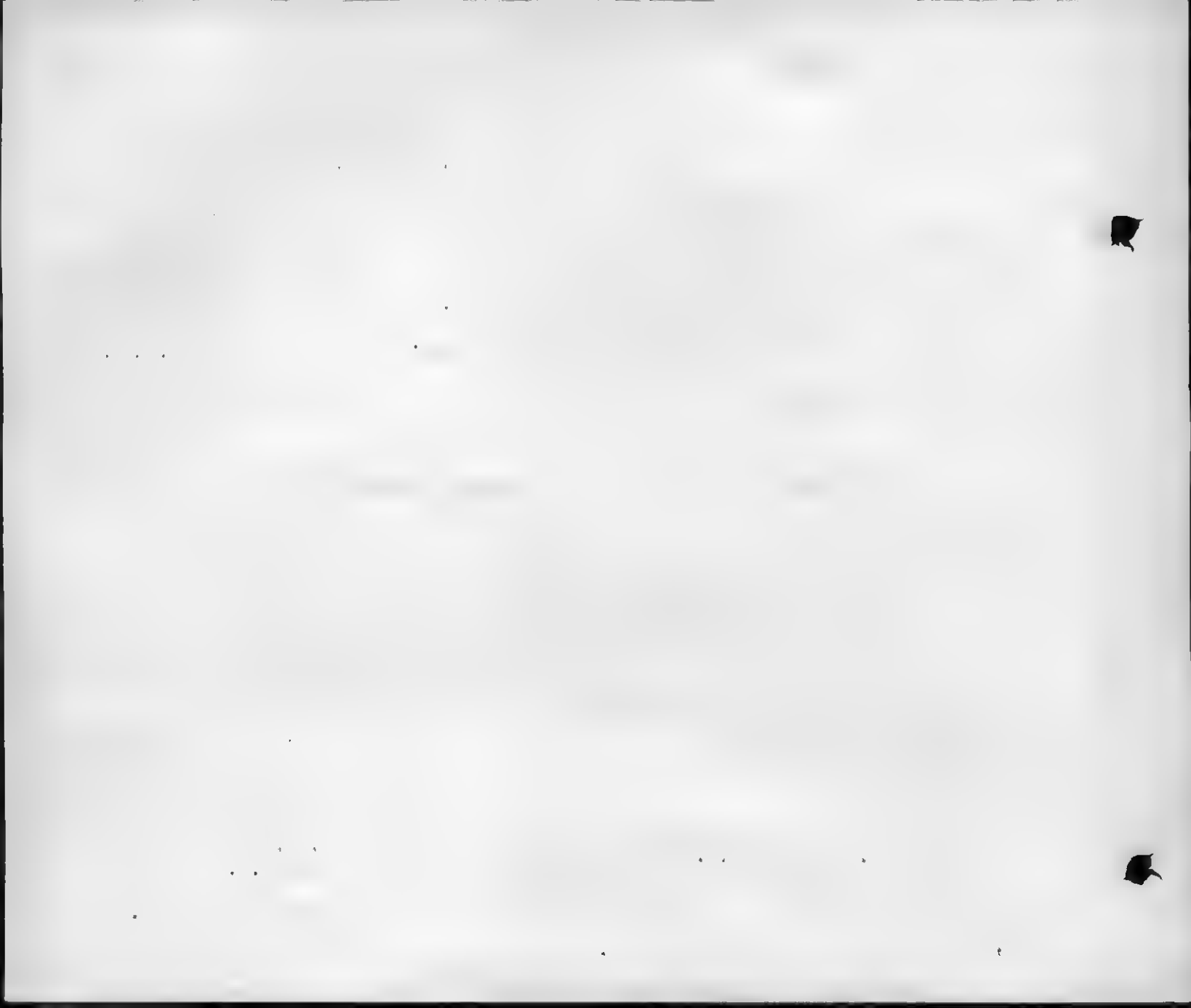
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8392

08386

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 6317 Kenilworth Ave.	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
NAME OF DECEASED (Type or print) Lilly W Seay		4 DATE OF DEATH July 13 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Sept. 1869	
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Harbaugh		14. MOTHER'S MAIDEN NAME Mary J. Warren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sarcoma left shoulder with metastases DUE TO 199X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 12 1961 to July 13 1961, that (I) (we) last saw the deceased alive on July 13 1961, and that death occurred at 12:45 PM from the causes and on the date stated above.			
22a. SIGNATURE James R. Goodson M.D.		22b. DATE SIGNED July 14/61	
22c. PHYSICIAN'S NAME (Type) James R. Goodson, M.D.		22d. ADDRESS 1746 K St. N.W. Washington 6 D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/16/61	
23c. NAME OF CEMETERY OR CREMATORY Confederate Cemetery		23d. LOCATION (City, town, or county) Spotsylvania Va. (State)	
24 FUNERAL DIRECTOR'S SIGNATURE F. Gacsh's Sons		25a. REC'D BY REGISTRAR DATE JUL 17 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Anton S. Hoad	



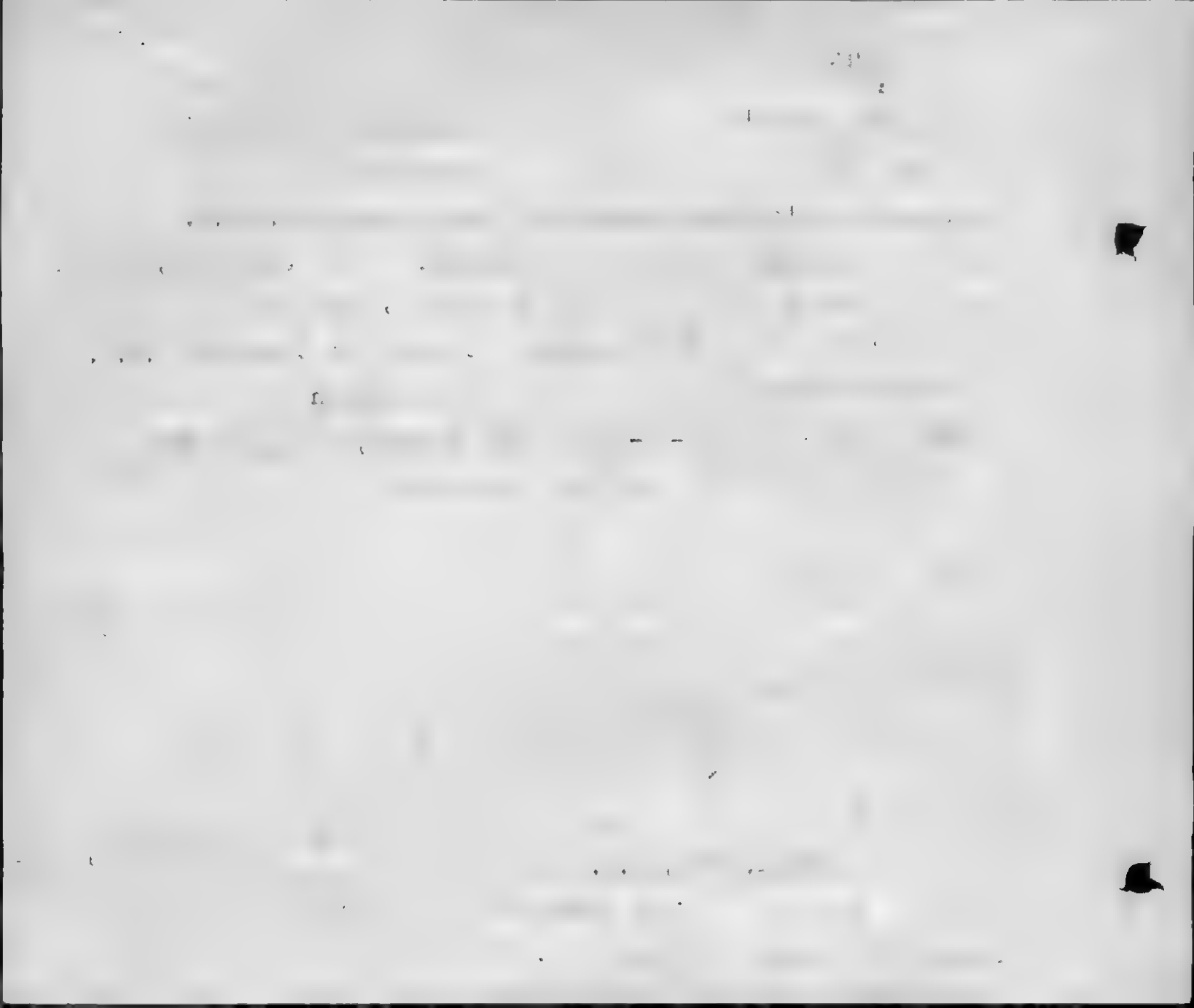
1
FOR STATE
HEALTH DEPT.

TO THE JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8393 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 88887

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 6325 Kansas Ave., N.E.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 47	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon Sherman		4. DATE OF DEATH Last December 1, 1914 Month July Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isadore Sherman		14. MOTHER'S MAIDEN NAME Dora Slipian	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 1932-34 578-01-4131	
17. INFORMANT Gary Sherman,		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO (b) CORONARY THROMBOSIS and ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-2-61	
22c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery		22d. LOCATION (City, town, or country) (State) Oxon Hill, Maryland	
23. FUNERAL DIRECTOR B. Danzansky & Sons		24a. REC'D BY REG. STRAR Aug 4 '61	
ADDRESS 3501 14th St., NW		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
ma. retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8394

00388

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 Hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5406 Patterson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle MAE Last Shirley				4. DATE OF DEATH Month July Day 28 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 16, 1890	
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71		11. BIRTHPLACE (State or foreign country) GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) GEORGIA	
13. FATHER'S NAME CHARLES R. HERRING				14. MOTHER'S MAIDEN NAME LIZA JANE MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address (If yes, give war or dates of service)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 132X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC HEART DISEASE							
INTERVAL BETWEEN ONSET AND DEATH 36 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/20 19 61 to 7/22 19 61 , that (I) (we) last saw the deceased alive on 7/22 19 61 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Norman D. Comeau M.D.				22b. DATE SIGNED 7/22/61			
22c. PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.				22d. ADDRESS 3503 Penny St Mt Rainier Md			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/25/61		23c. NAME OF CEMETERY OR CREMATORY FORT WINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) BLADENSBURG MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Riverdale W. M. Chambers				25a. REC'D BY REGISTRAR DATE JUL 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

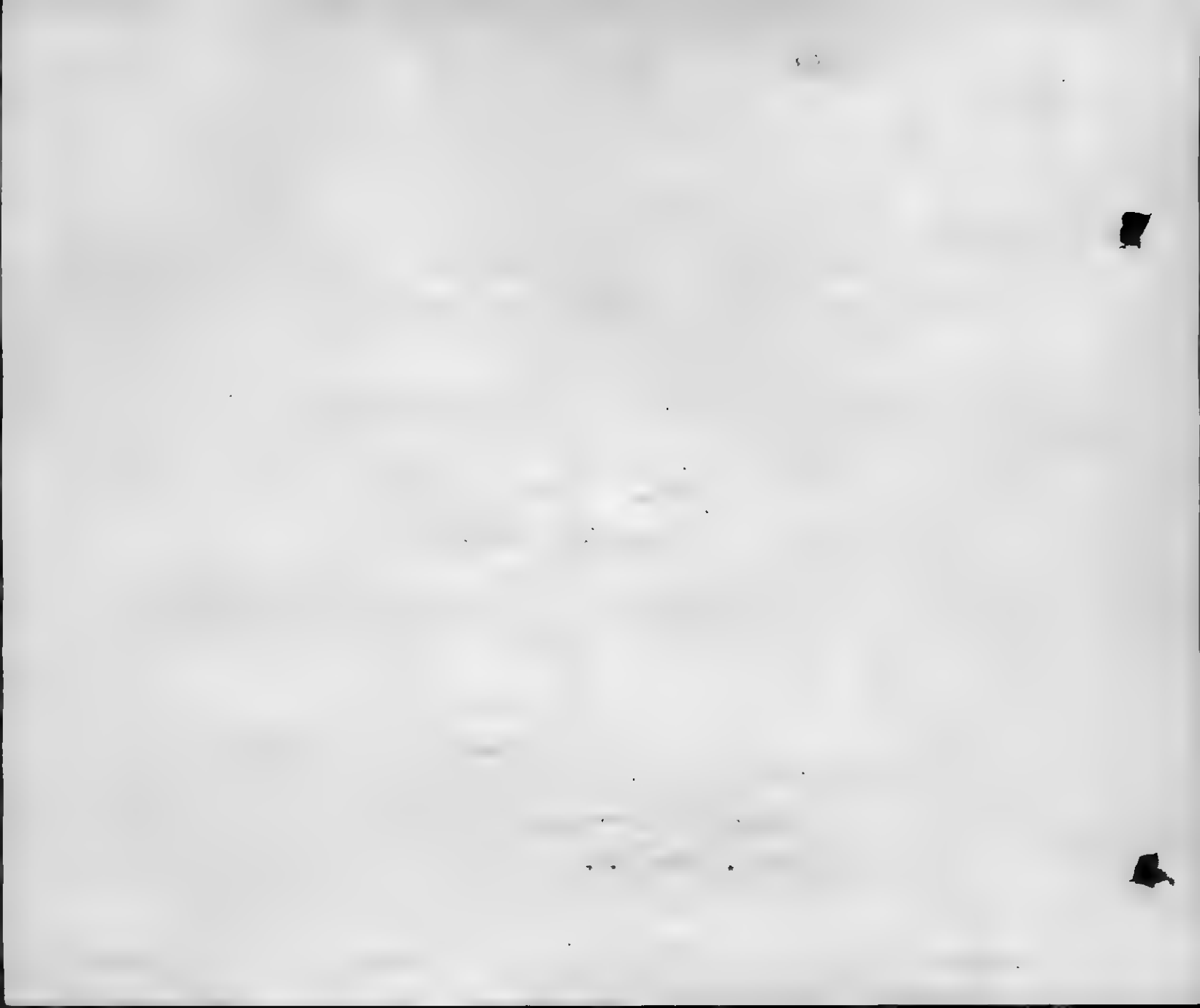
VR A15 (4)
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8395											
98383											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington 21</u> c. LENGTH OF STAY IN 1b <u>21</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>USAF Hospital Andrews</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, 2112</u> d. STREET ADDRESS <u>2503 RIVIERA ST. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Susan Lynn Simpson</u> First Middle Last 4. DATE OF DEATH <u>July 4 1961</u> Month Day Year						9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>26 June 1958</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>SAN Antonio, TEXAS</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Robert A. Simpson</u>						14. MOTHER'S MAIDEN NAME <u>Margaret A. Godlove</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Father</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 154.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Congenital Heart Disease</u> (c) <u>None</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> a. work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>16 August, 1960</u> to <u>3 July, 1961</u> , that (I) (we) last saw the deceased alive on <u>3 July, 1961</u> and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John A. Moore</u> M.D. 22b. DATE SIGNED <u>4 Jul 61</u>											
22c. PHYSICIAN'S NAME (Type) <u>John A. Moore M.D.</u> 22d. ADDRESS <u>USAF Hospital Andrews</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>7 JULY 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u> 23d. LOCATION (City, town or county) (State) <u>ARLINGTON VA.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kimble Funeral Home Inc.</u> ADDRESS <u>816 H St. N.E.</u> 25a. REC'D BY REGISTRAR <u>DATE JUL 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>											



DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

CO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

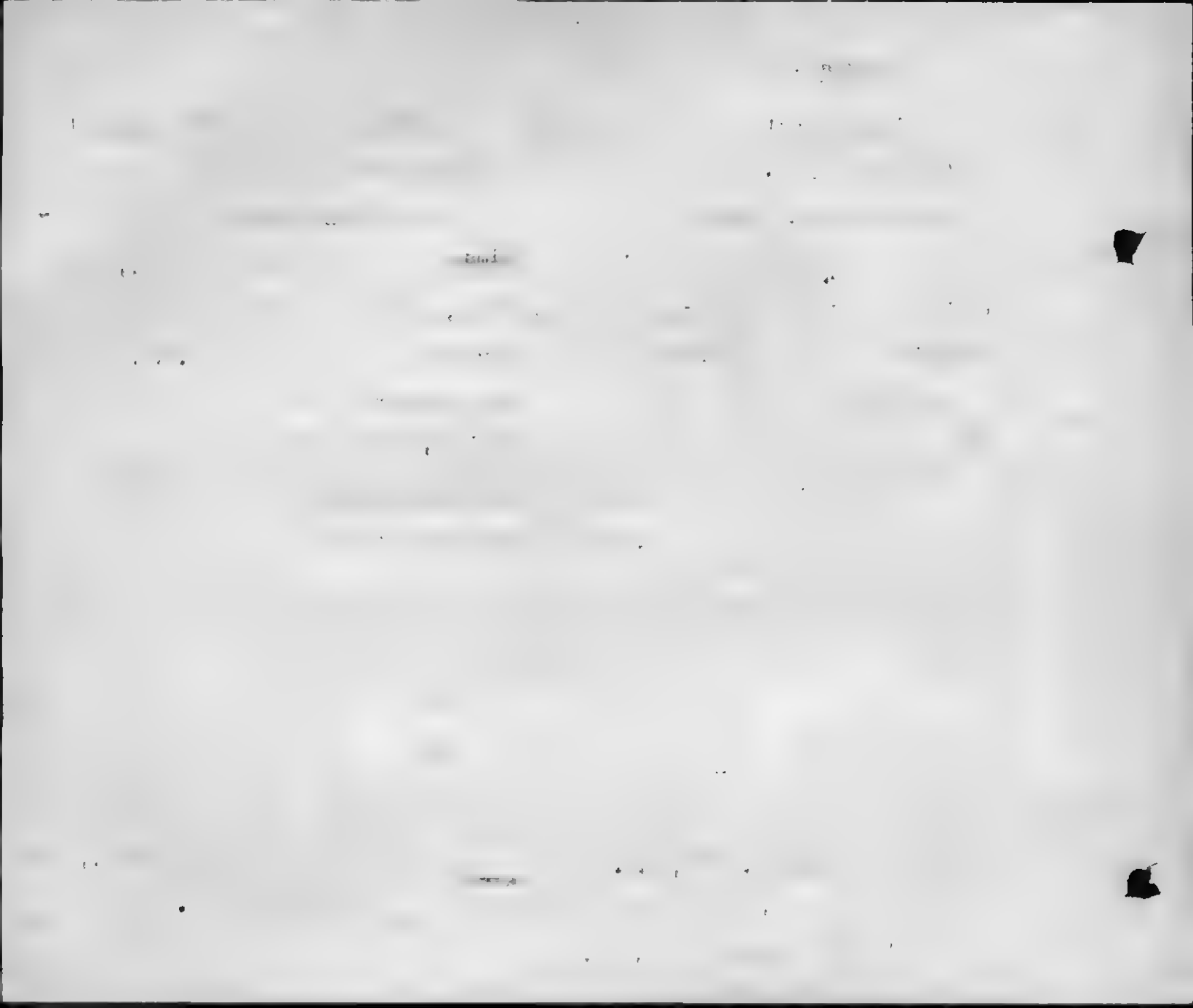
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8396

02390

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; residence after death) a. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. DATE OF BIRTH	
6. COLOR OR RACE		7. AGE (In years last birthday)	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. IF UNDER 24 HRS. Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
11. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		13. SOCIAL SECURITY NO.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		15. INFORMANT	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		16. ADDRESS	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		17. MARION SIMMS, same as # 2	
442 X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. ACTUAL SIGNATURE		24. DATE SIGNED	
23. EXAMINER'S NAME (Type)		24. July 14th., 1961	
25. BURIAL, CREMATION, REMOVAL (Specify)		25. DATE THEREOF	
25. George Washington		25. July 17, 1961	
26. FUNERAL DIRECTOR		26. ADDRESS	
26. F. Gasch's Sons, Hyattsville, Md.		26. Hyattsville, Md.	
27. REC'D BY REGISTRAR		27. REGISTRAR'S SIGNATURE	
27. JUL 18 '61		27. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8397

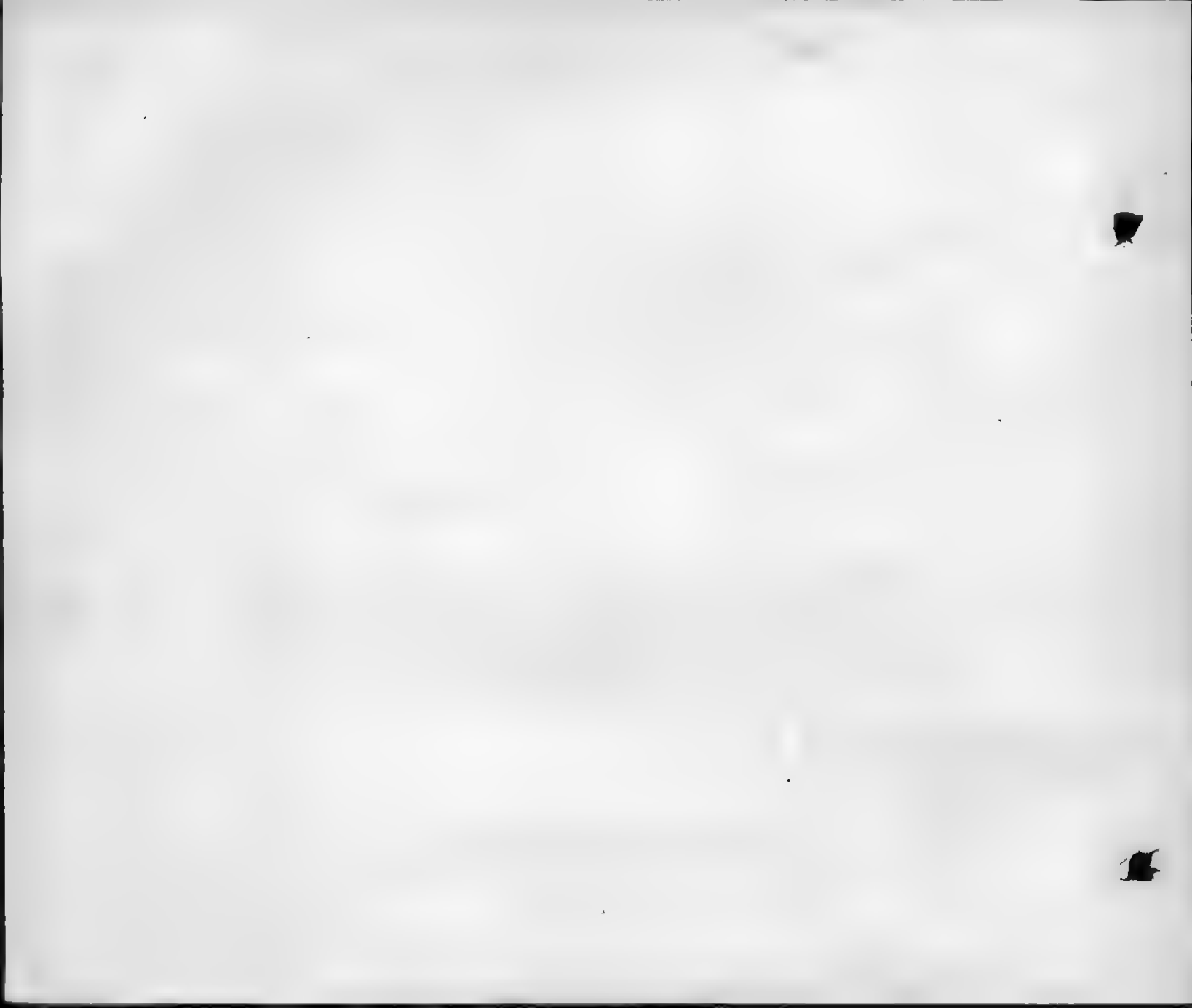
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08391

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glass Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glass Manor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103-Audrey Lane</u>		d. STREET ADDRESS <u>1103 Audrey Lane 205</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Frank</u> First Middle Last		4. DATE OF DEATH <u>July 7</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1912</u> 9. AGE (In years last birthday) <u>49</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Windber Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. Sliva</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miallo</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT <u>Susan M. Sliva</u> Address <u>Same as D 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, lung with mediastinal metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastases</u> (c) <u>7 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11-X</u> (b) <u>7 months</u> (c) <u>7 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Dec 3</u> 19 <u>60</u> to <u>July 7</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> 19 <u>61</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank R. Shea</u>		22b. DATE SIGNED <u>7/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK R. SHEA</u>		22d. ADDRESS <u>4100-22nd NE Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-10-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Hyatt</u>		25a. REC'D BY REGISTRAR <u>131-11th St SE</u> DATE <u>JUL 10 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8398

CERTIFICATE OF DEATH

08392

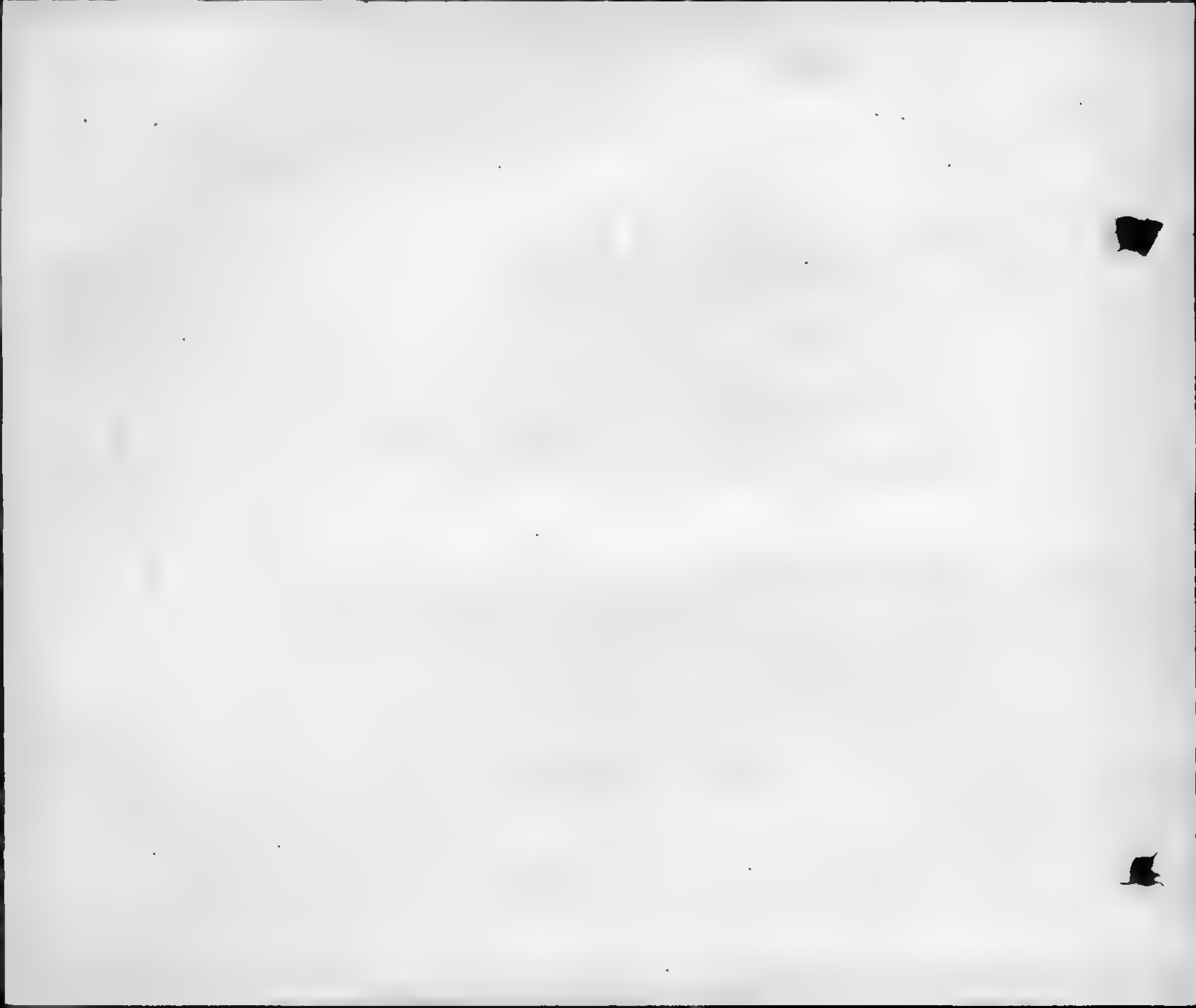
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabrest, Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cabrest, Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josaph DANIEL SMITH</u>		4. DATE OF DEATH Month Day Year <u>July 1 1961</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13 1875</u>
9 AGE (In years less birthday) <u>86</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmers</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11 BIRTHPLACE (State or foreign country) <u>Pr. Geo Co Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Welles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rabuth H. Smith, Laurel Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>1 day</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO <u>10 yrs</u>			
(c) <u>Benl Arteriosclerosis</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/28 1961</u> to <u>7/1 1961</u> that (I) (we) last saw the deceased alive on <u>6/30 1961</u> and that death occurred at <u>3 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u> M.D.		22b. DATE SIGNED <u>7/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>		22d. ADDRESS <u>Laurel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 3, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Davidson, Laurel, Md.</u>		25a. REC'D BY REGISTRAR <u>BATUL 5 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Felt</u>	

(M)

X

(I)

1



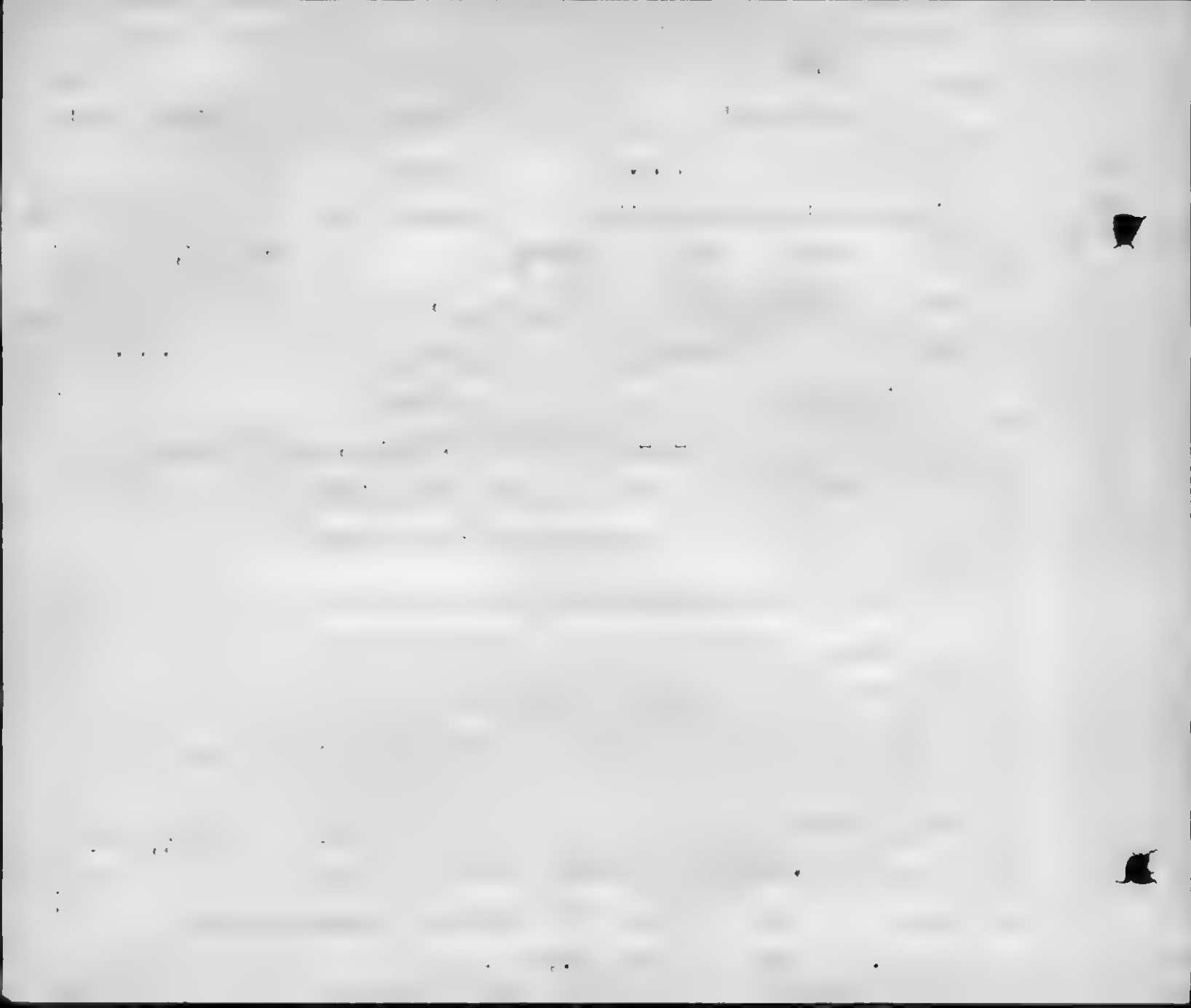
1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY in lb D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS Brookland Road					
NAME OF DECEASED (Type or print) Edna Marie Snowden						4. DATE OF DEATH Month July Day 6 Year 1961					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1900		9. AGE (in years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Fleet						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-26-2499		17. INFORMANT Dorothy J. Snowden, same address as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 8, 1961											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-11-61		22c. NAME OF CEMETERY OR CREMATORY Church of Ascension		22d. LOCATION (City, town, or country) (State) Bowie Md.			
23. FUNERAL DIRECTOR Myrtle K. Rollins				4339 Hunt Pl., N.E.		24a. REC'D BY REGISTRAR JUL 12 '61		24b. REGISTRAR'S SIGNATURE Charles L. Hume			



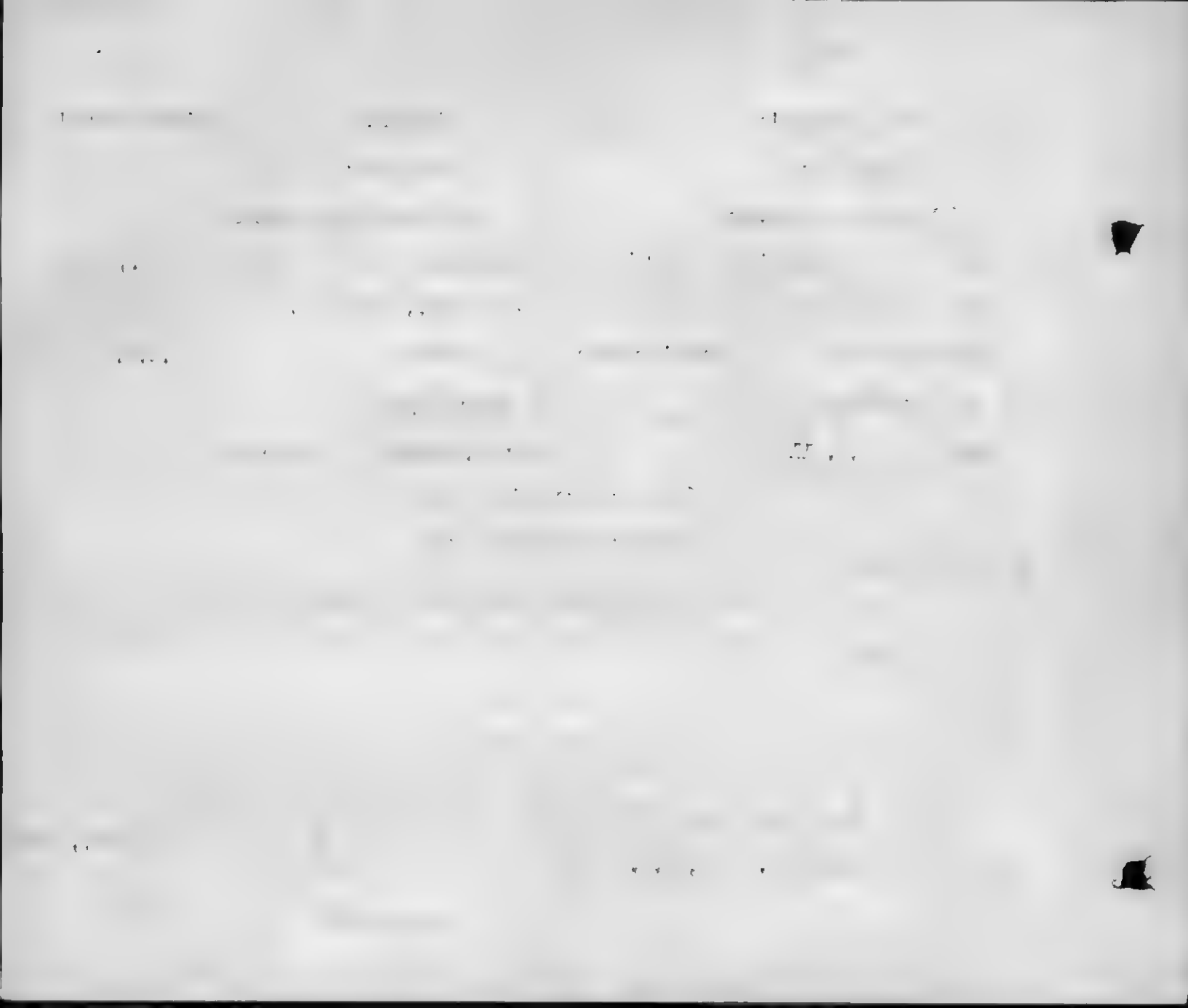
1
FOR STATE
HEALTH DEPT.

Delay is necessary, if possible, to delay execution of this certificate until 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. MISE
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
82394									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takomo Park					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takomo Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 410 Ethan Allen Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Martin Greig Steele					4. DATE OF DEATH July 14th., 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH July 3rd., 1904				
9. AGE (In years last birthday) 57 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lyntype operator					10b. KIND OF BUSINESS OR INDUSTRY Evening Star				
11. BIRTHPLACE (State or foreign country) Canada					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Arthur Steele					14. MOTHER'S MAIDEN NAME Clara Tryon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II					16. SOCIAL SECURITY NO. Mary T. Steele				
17. INFORMANT Same as #2					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED July 14th., 1961									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF July 17-1961									
22c. NAME OF CEMETERY OR CREMATORY St. Elizabeth's Cemetery									
22d. LOCATION (City, town, or country) (State) Prince George's Co. Md.									
23. FUNERAL DIRECTOR Arthur T. Hutton									
24a. REC'D BY REGISTRAR JUL 17 '61									
24b. REGISTRAR'S SIGNATURE Arthur T. Hutton									



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

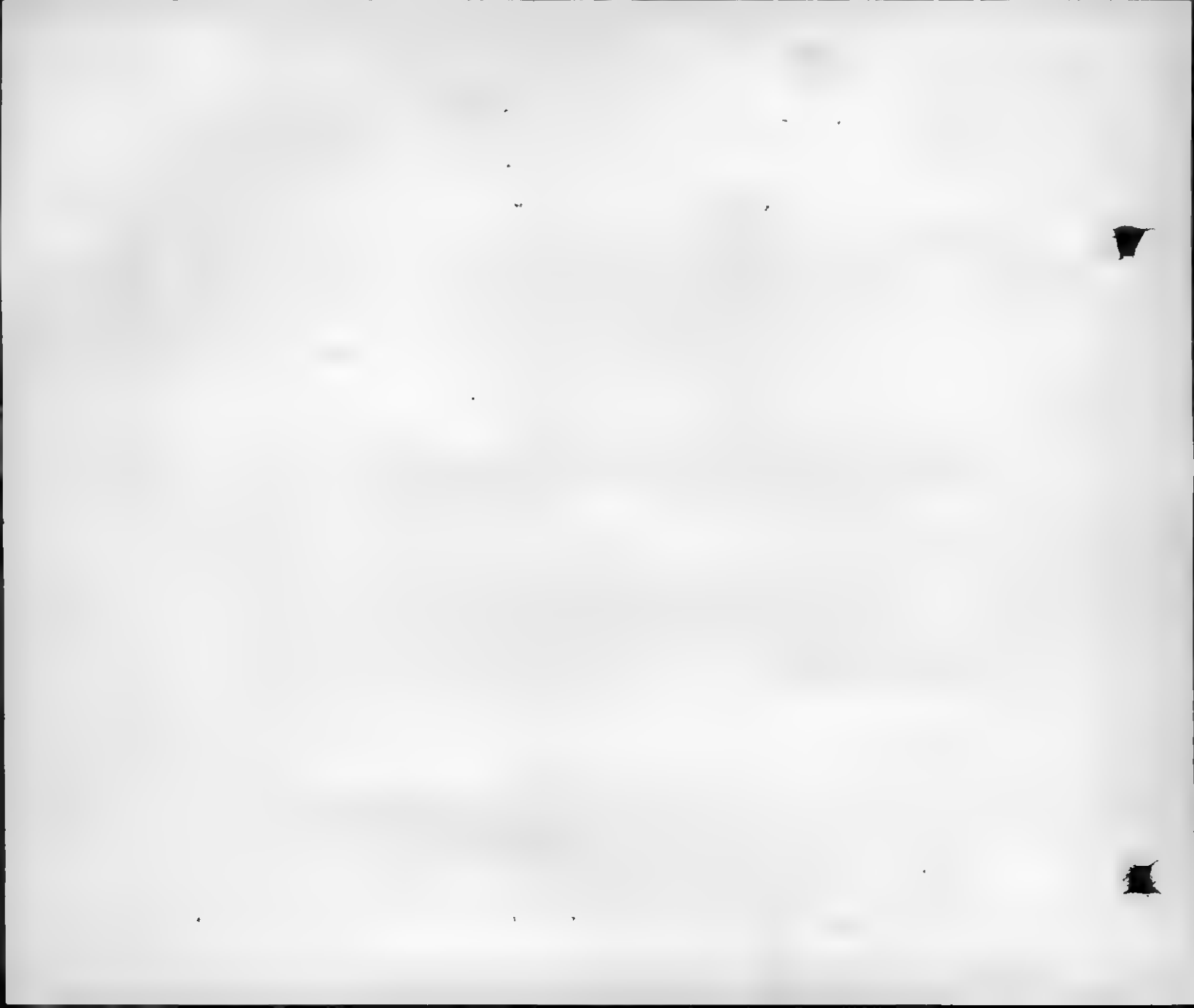
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8401

08395

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS Route 1 Box 750			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Stetler				4. DATE OF DEATH Month Day Year July 5 1961						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1961		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS --- yrs Months Days Hours Min. 52		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Lewis Edward Stetler				14. MOTHER'S MAIDEN NAME Mary Sugart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO premature rupture of membranes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) premature rupture of membranes DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 5, 1961 to July 5, 1961 , that (I) (we) lost saw the deceased alive on 7/5 19 61 and that death occurred at 1:45 from the causes and on the date stated above.										
22a. SIGNATURE [Signature]				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) F. I. KAIBMI MD				22d. ADDRESS 1801 Eye St. N. W.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital			23d. LOCATION (City, town, or county) (State) Cheverly, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature]						25a. REC'D BY REGISTRAR DATBUL 24 '61		25b. REGISTRAR'S SIGNATURE [Signature]		

Harry W. Pepp, Jr., Administrator



CERTIFICATE OF DEATH

Reg. Dist. No. 88396

8402

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>PRINCE GEORGES</u> Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HEIGHTS Md.</u>	
c. LENGTH OF STAY IN 1b <u>4-yr</u>		d. STREET ADDRESS <u>104 Woodland DR.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>ELIZABETH</u> Last <u>STEVENS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Aug. 1887</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>PHILLIP WISTER</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ballinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Evelyn Forest</u> Address <u>Forest Hts. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>114-5X Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1955</u> to <u>July 19, 1961</u> , that I last saw the deceased alive on <u>July 19, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max E. Feldman MD</u>		ADDRESS (Street, city or town, state) <u>3800 S. Capitol St. Wash. 20 D.C.</u> DATE SIGNED <u>20 July 1961</u>	
PHYSICIAN'S NAME (Type) <u>MAX E. FELDMAN M.D.</u>		<u>Chensed Registered D.C. + Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-24-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Semmons Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash. 20 DC</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08397

1. PLACE OF DEATH a. COUNTY Prince Georges Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS Brown Bridge Road	
3. NAME OF DECEASED (Type or print) First Middle Last Bruce Baby Calvin Boy Stockman, Jr.		4. DATE OF DEATH Month Day Year July 14 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 July 1961
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bruce Calvin Stockman		14. MOTHER'S MAIDEN NAME Peggy Ann Wedule	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Presumptive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 13 1961 to July 13 1961 that (I) (we) last saw the deceased alive on July 13 1961, and that death occurred July 14 1961 from the causes and on the date stated above			
22a. SIGNATURE <u>George Tobooguel</u> M.D.		22b. ADDRESS 1723 M St., N.W., Washington 6, D.C.	
22c. PHYSICIAN'S NAME (Type) Dr. Labarraque., M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7/21/61	23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital	23d. LOCATION (City, town, or county) Cheverly, Md. (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Krasa</u>		25a. REC'D BY REGISTRAR DATE JUL 24 '61	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	



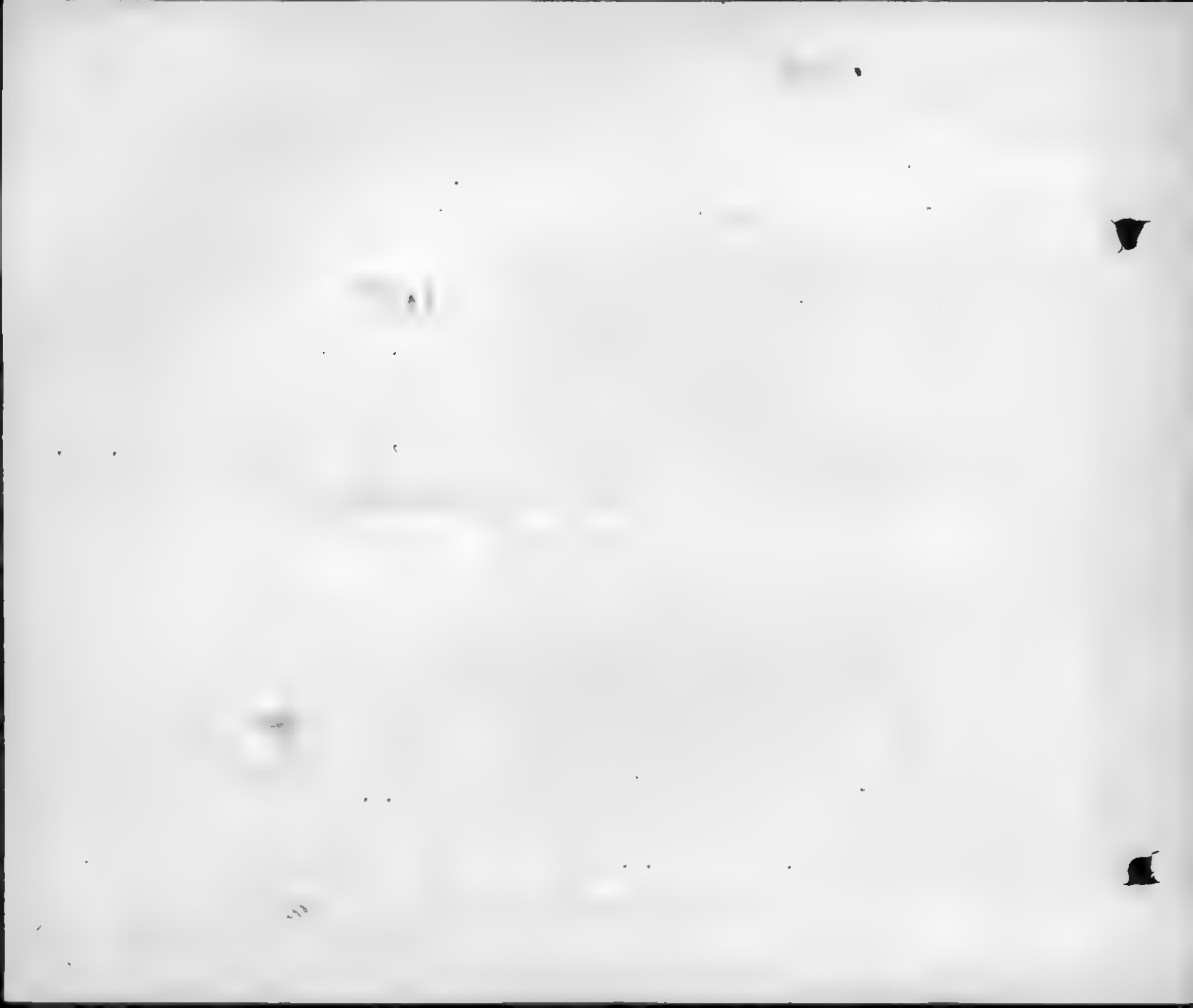
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8404

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08398

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights 30	
3 NAME OF DECEASED (Type or print) First Middle Last Waver Sumpter		4. DATE OF DEATH Month Day Year July 25 1961	
5 SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897
9 AGE (In years lost birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Santee, S.C.
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Roland Grayton (Doc)	
14. MOTHER'S MAIDEN NAME Elizabeth ? (Doc)		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Wad. Sumpter, Son, 910-64 Avenue Cedar Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Cordial Hemorrhage (b) DUE TO Generalized Arteriosclerosis (c) DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 21 Jul 61 to 25 Jul 1961, that (we) last saw the deceased alive on 25 Jul 61, and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas G. Maloney M.D.		22b. DATE SIGNED 25 Jul 61	
22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.		22d. ADDRESS 4814 71st Avenue, Landover Hills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) July 30, 1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Church cemetery		23d. LOCATION (City, town or county) Santee SC (State)	
24. FUNERAL DIRECTOR'S SIGNATURE L. E. Murray & Son 1337 10th St. N.W. #167		25a. REC'D BY REGISTRAR DATE JUL 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			



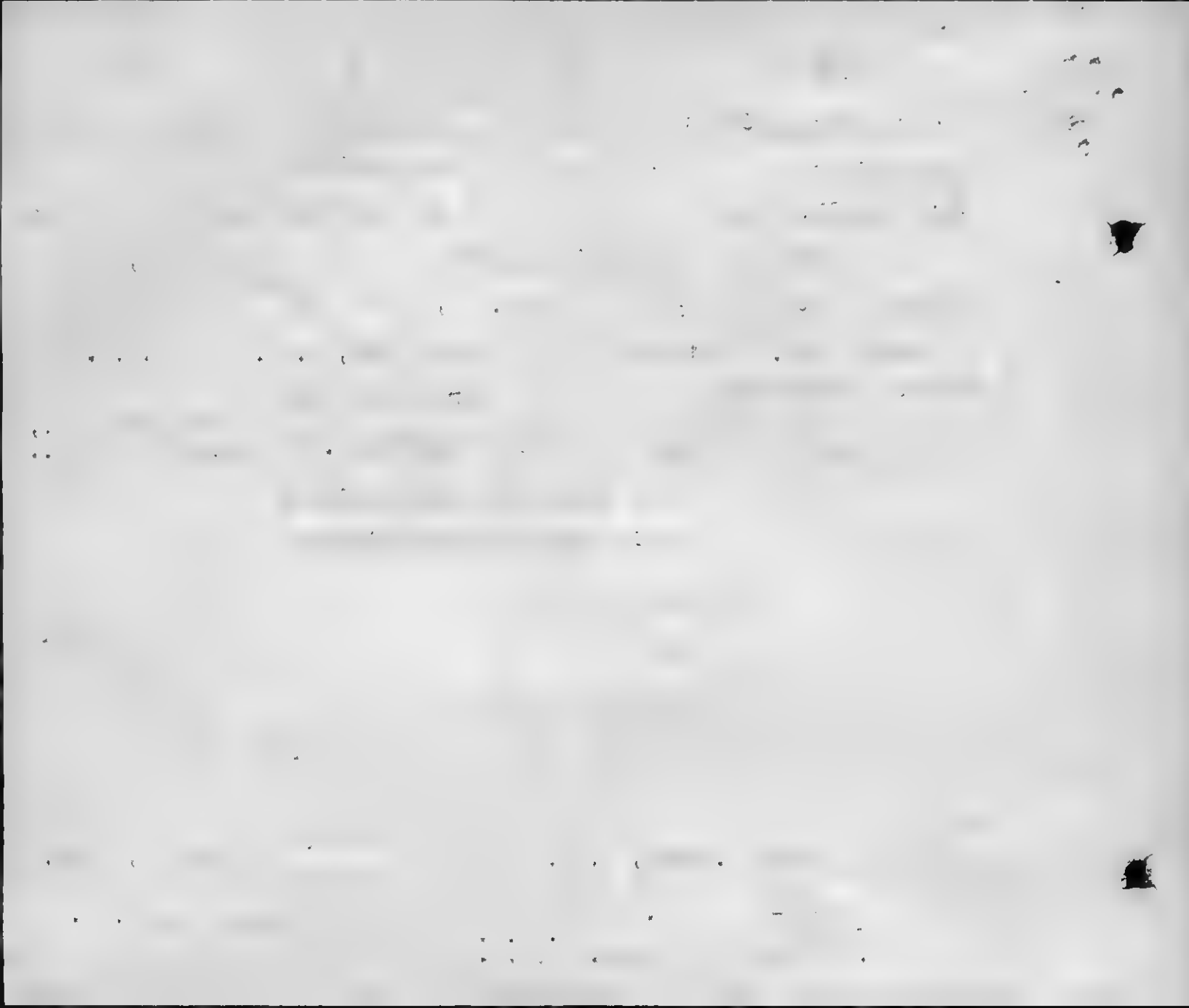
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00393

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 18 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4922 LaSalle Road		d. STREET ADDRESS 4922 LaSalle Road	
3. NAME OF DECEASED (Type or print) MARY FLORENCE TASTET		4. DATE OF DEATH July 19, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1874 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Joseph Dawson		14. MOTHER'S MAIDEN NAME Mary Lydia Wise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Waldo Tastet Sr.		Address 7021 Pyle Rd., Bethesda 14, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 412X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular Renal Disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JAMES I. BOYD, M.D.		DATE SIGNED July 19, 1961.	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Washington D. C.	
23. FUNERAL DIRECTOR FRANCIS J. COLLINS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE July 24 '61	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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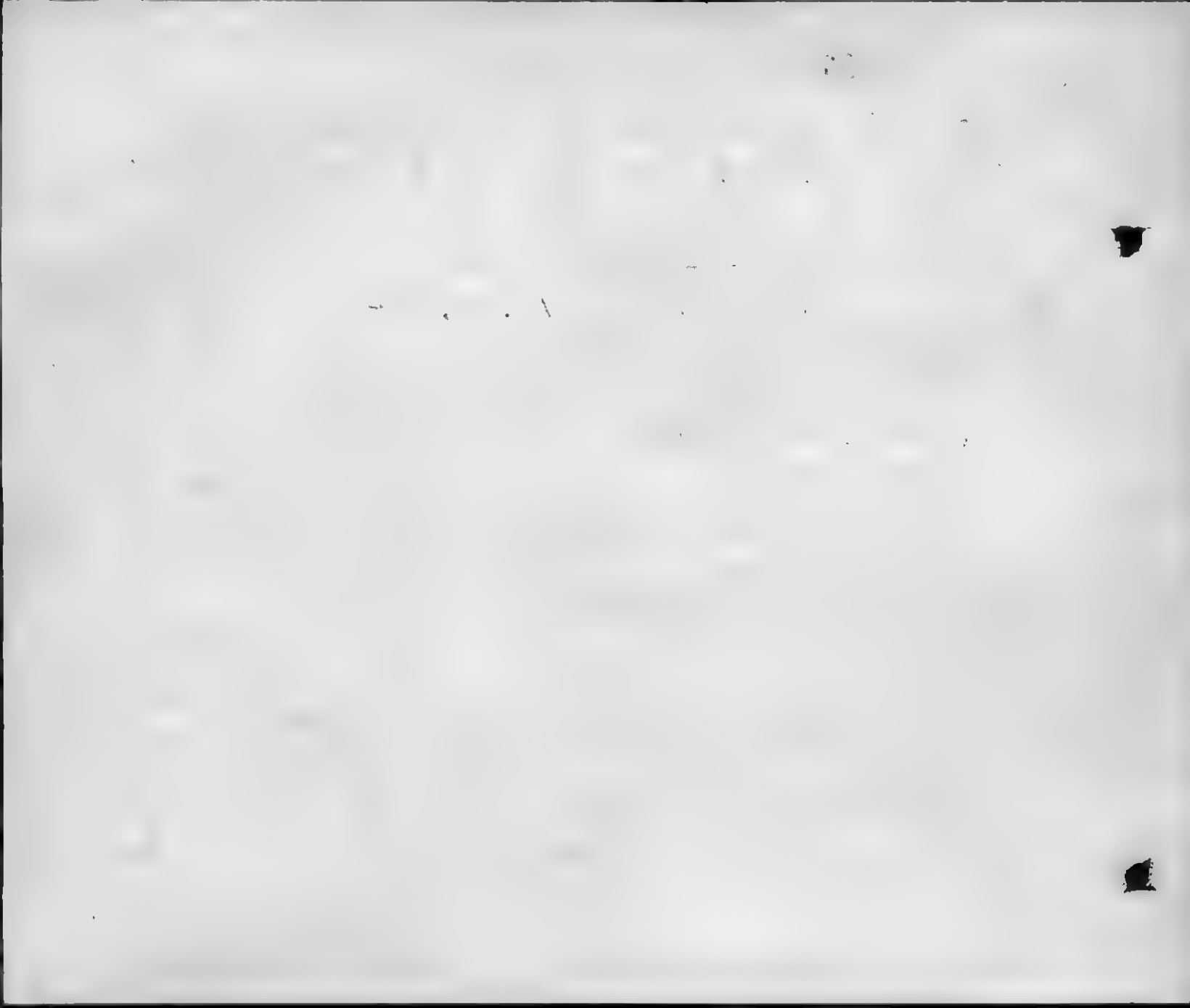
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8405

08400

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>RURAL-CLINTON</u> c. LENGTH OF STAY IN 1b <u>40 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT 1 Box 635</u>				2. USUAL RESIDENCE [Where deceased lived, if institution; Residence before admission] a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO'S.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-CLINTON</u> d. STREET ADDRESS <u>1 RT, Box 635</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>NORA CECELIA THORNE</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>3</u> Year <u>1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1884</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>HENRY KING</u>				14. MOTHER'S MAIDEN NAME <u>ADELAIDE WHITE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give where & dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>SON - WILLIAM E. THORNE JR.</u> Address <u>Burgess Road, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u> (c), stating the underlying cause last. <u>15 MIN.</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE PYELONEPHRITIS - 2 DAYS</u> (b) <u>NONE</u> (c) <u>NONE</u>													
20a. ACCIDENT WAS UNDERLYING, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>NONE</u> p.m.				20d. INJURY OCCURRED While <u>NONE</u> at work <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>NONE</u>		20f. (City or town) <u>NONE</u>		(County) <u>NONE</u> (State) <u>NONE</u>			
21. I certify that (I) (as hospital) attended the deceased from <u>SEPT. 5, 1957</u> to <u>Present</u> that (I) (as) saw the deceased alive on <u>JULY 3, 1961</u>, and that death occurred at <u>11:30</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/3/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D., BRANCH AVE., CLINTON, MD.</u>								22d. ADDRESS <u>West.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 6 - 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				23d. LOCATION (City, town or county) <u>Switzland, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros 1661 - gd Rogers Rd & E. DC</u>								25a. REC'D BY REGISTRAR <u>BUL 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8407

08401

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		3. NAME OF DECEASED (Type or print) Ruth J. Tibbs		4. DATE OF DEATH July 23, 1961		5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-19		9. AGE (in years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11. BIRTH PLACE (County & State or foreign country) Lawrenceville, Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Russell Jarrett		14. MOTHER'S MAIDEN NAME Fannie Wheeler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 231 22 8851	
17. INFORMANT Reese Tibbs		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction due to Paralytic Ileus DUE TO Diabetes Mellitus, uncontrolled (b) Pyosalpinx, right DUE TO Submucous leiomyofibroma of uterus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 48 hours		21. I certify that (this hospital) attended the deceased from July 23, 1961 to July 29, 1961 that (we) last saw the deceased alive on July 29, 1961 and that death occurred at 11:45 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Francis X. Carillo, M.D.		22b. PHYSICIAN'S NAME (Type)		22c. ADDRESS 1013 University Blvd. Silver Spring, Md.		22d. DATE SIGNED 7/30/61		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Va.		23e. STATE Va.	
24. FUNERAL DIRECTOR'S SIGNATURE K. Rollins		24a. ADDRESS 4339 Hunt Pk		24b. DATE AUG 2 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Frank		24d. REGISTRAR'S NAME Arthur S. Frank	



FOR STATE
HEALTH DEPT.

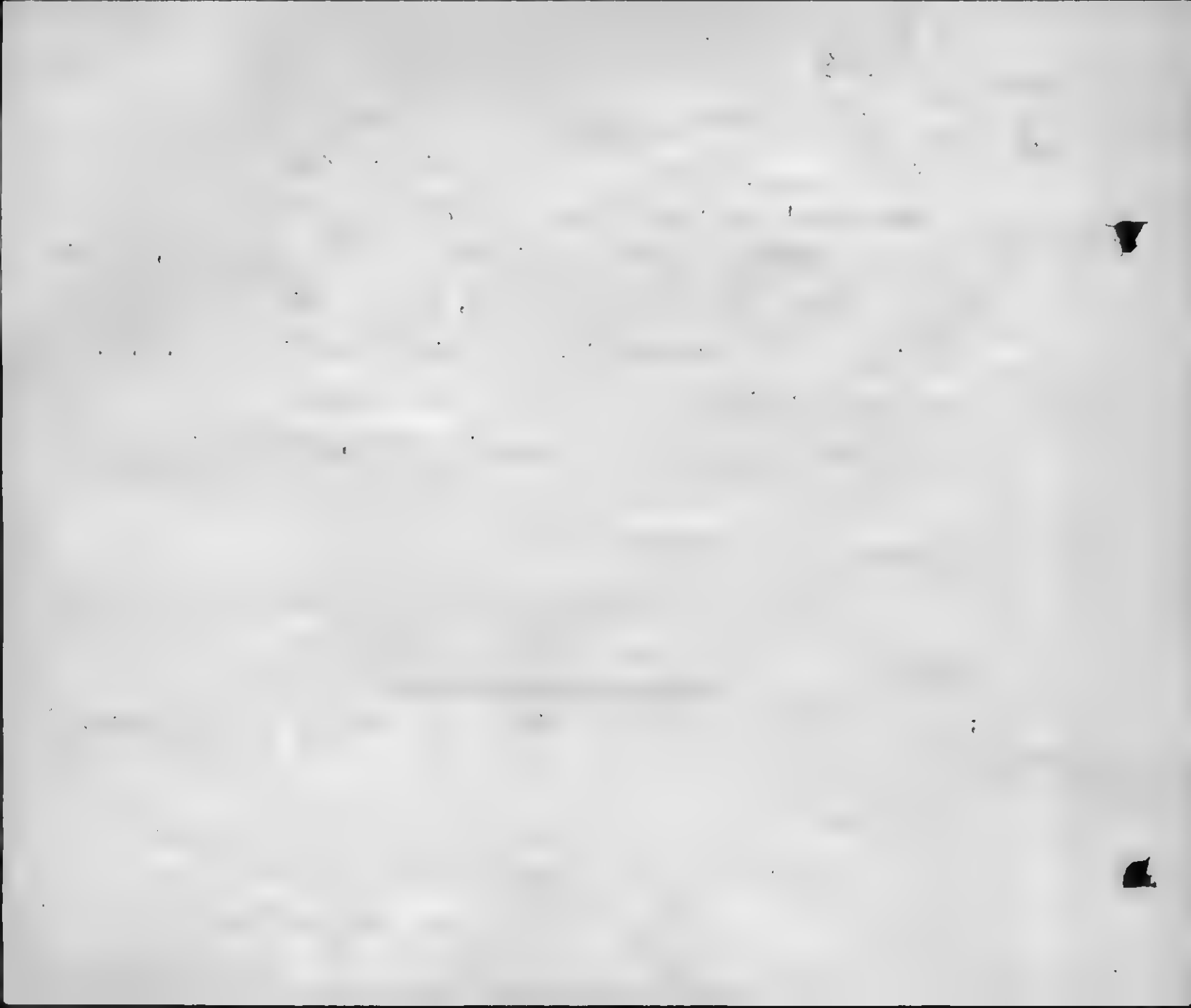
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08402

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY in lb BOA		d. STREET ADDRESS 8712 Bradford Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Middle Last	4. DATE OF DEATH	Month Day Year
Stanton	Edward	Tippett	July 4, 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1915
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Edward Tippett		14. MOTHER'S MAIDEN NAME Edna Pearl Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 579-05-8402	
17. INFORMANT Marguerite Tippett, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia			
DUE TO (b) Drowning			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowning in the potomac river			
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 7/4 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	20f. (City or town) (County) (State) Oxon Hill Prince George, Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)			
DATE SIGNED 7/4/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-7-61	Arlington Natl. Cem.	Arlington, Virginia
23. FUNERAL DIRECTOR W. W. Chambers Co Riverdale, Md			
24a. REC'D BY REGISTRAR DATE JUL 10 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Kralik			

MEDICAL CERTIFICATION



may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8403

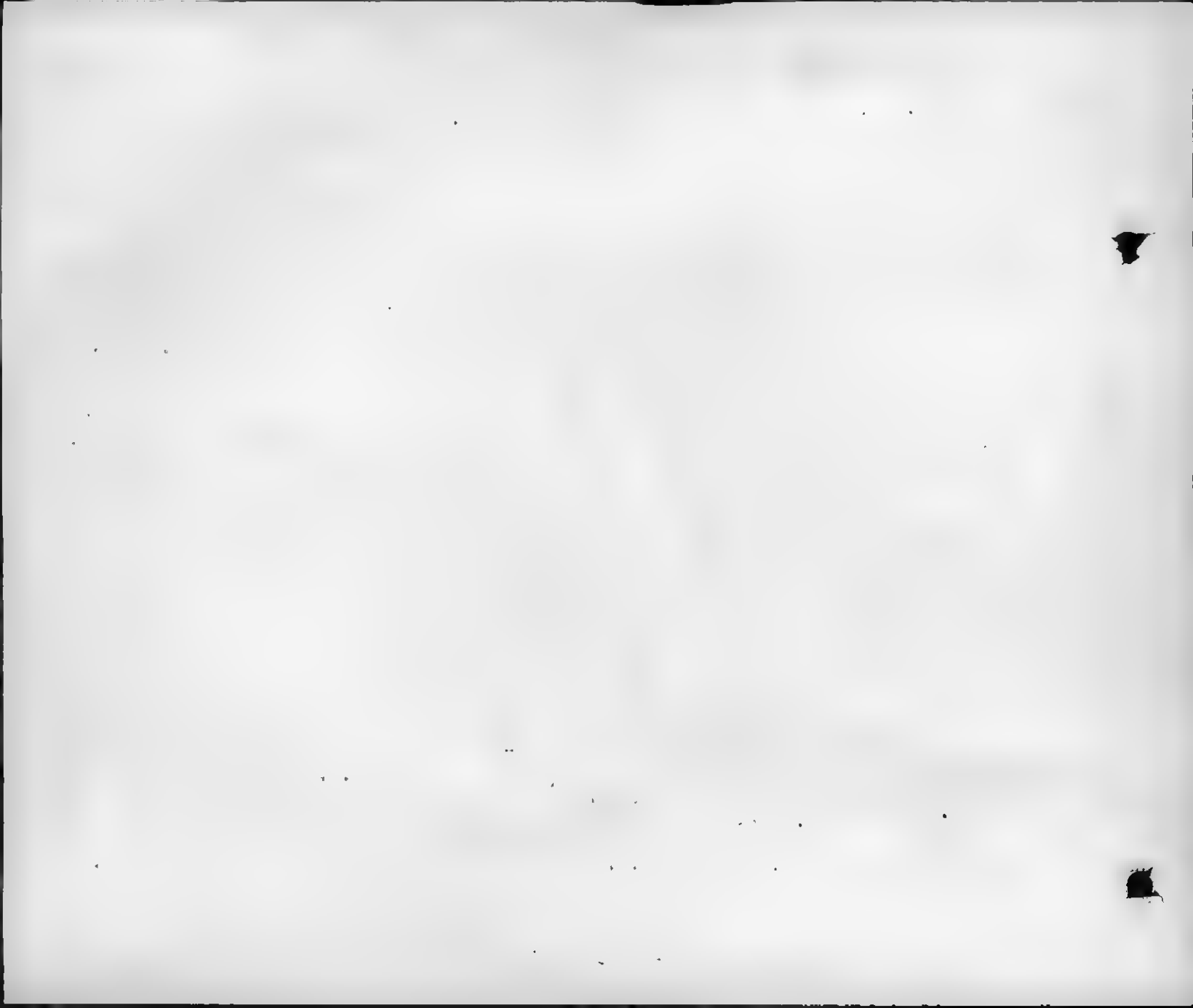
Item 9 Film G291

08403

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 51 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Turner Last Turner		4. DATE OF DEATH Month July Day 15 Year 1961	
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1919
9. AGE (In years last birthday) 42 yrs		10. IF UNDER 1 YEAR: Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Columbus, Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Powell	
14. MOTHER'S MAIDEN NAME Minnie Gibson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph Turner	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X DUE TO Hypertensive Cardiovascular Renal Disease DUE TO years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1961 , to July 15, 1961 , that (I) (we) last saw the deceased alive on July 15, 1961 , and that death occurred at 9:50, Home the causes and on the date stated above.			
22a. SIGNATURE William D. Rosson		22b. DATE SIGNED 7/16/61	
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.		22d. ADDRESS 5701 85th Avenue, Carrolton, M.D.	
23a. BURIAL, CREMATION REMOVAL (Specify) 7/17/61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Baldwin & White Funeral		23d. LOCATION (City, town, or county) (State) Columbus, Georgia	
24. FUNERAL DIRECTOR'S SIGNATURE Alex S. Pope Jr		25. REGISTRAR'S SIGNATURE Charles S. Evans	

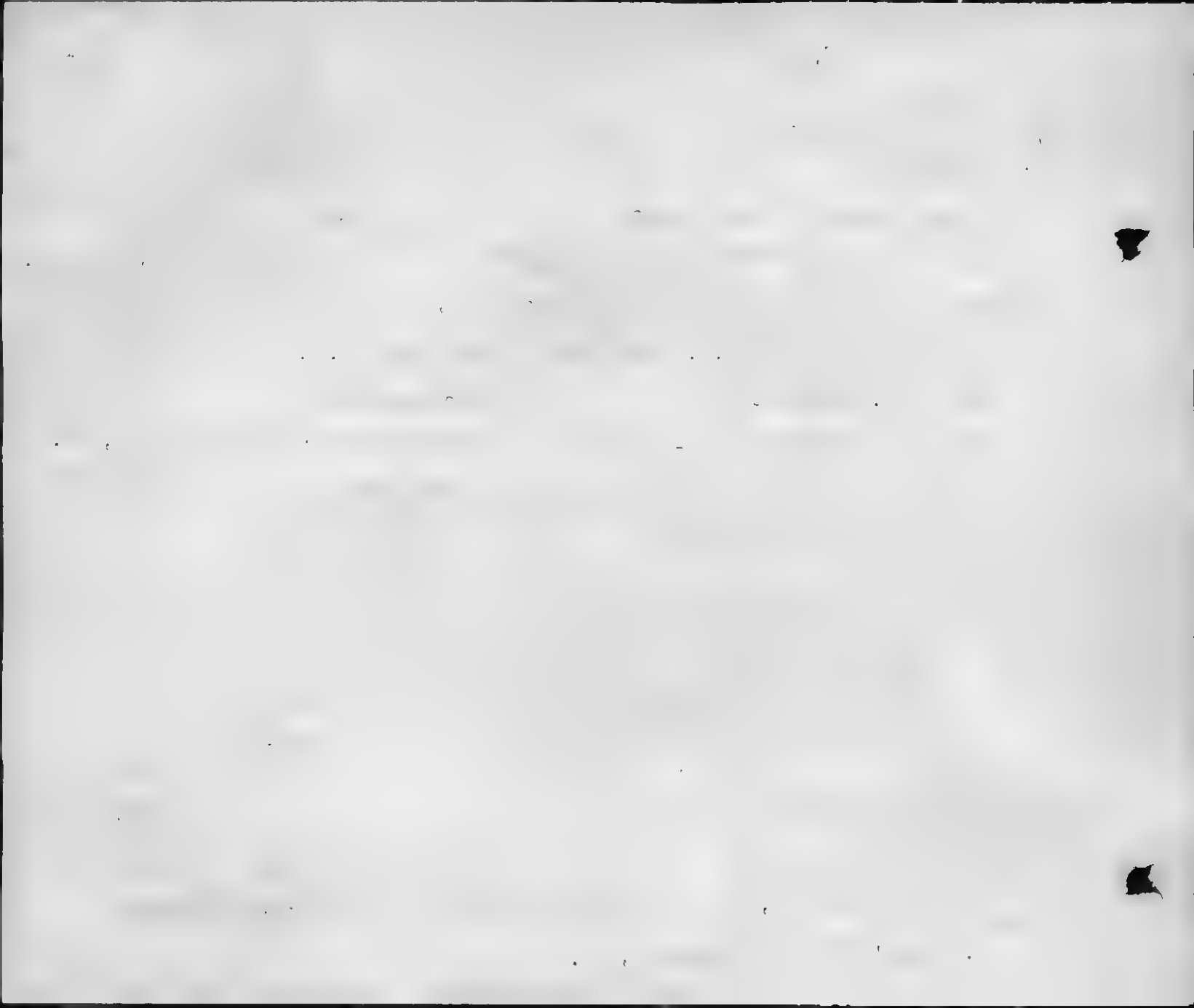
444-15th St SE

DATE JUL 18 '61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8410 CERTIFICATE OF DEATH 08404											
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9808 47th Avenue							
3. NAME OF DECEASED (Type or print) Kenneth S Van Fleet				4. DATE OF DEATH July 7, 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. CO. OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1903		9. AGE (in years last birthday) 58		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordinance				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government				11. BIRTHPLACE (Country & State, or foreign country) Washington D. C.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles E. VanFleet				14. MOTHER'S MAIDEN NAME Emma Galloway			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 004-24-8269				17. INFORMANT Elizabeth N Van Fleet Address College Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple post embolic stroke Conditions, if any, which gave rise to immediate cause (b) Brain aneurysm base of skull (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 61 , to 7/7 , 19 61 , that (I) (we) last saw the deceased alive on 7/6 , 19 61 , and that death occurred at 7/7 M, from the causes and on the date stated above.											
22a. SIGNATURE Julius Kauffman				22b. DATE SIGNED July 7, 1961				22c. PHYSICIAN'S NAME (Type) Julius Kauffman			
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 11, 1961				23c. NAME OF CEMETERY OR CREMATORIUM Arlington National			
23d. LOCATION (City, town or county) Arlington				(State) Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 13 '61			
25b. REGISTRAR'S SIGNATURE Calvin E. Kline											



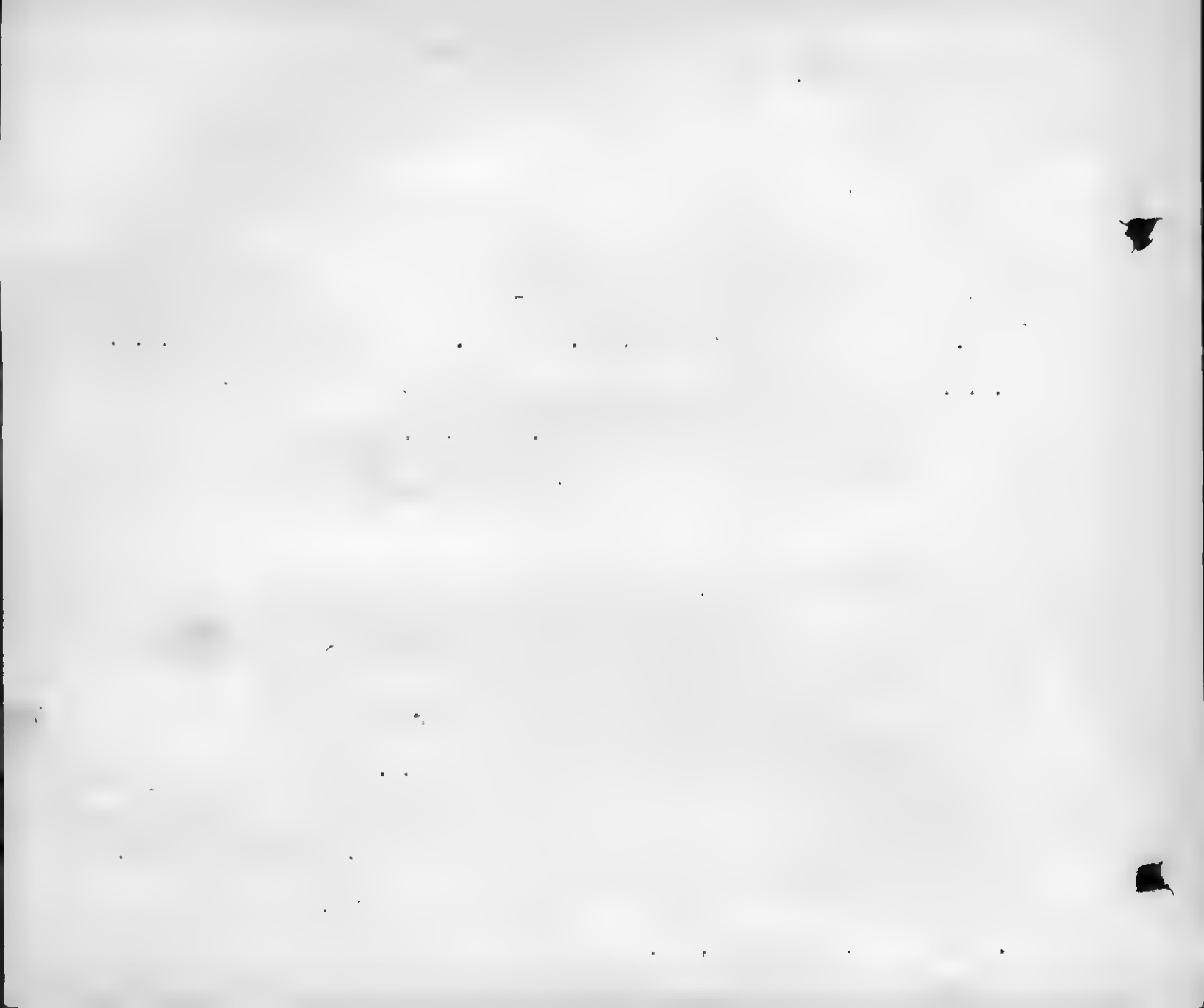
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8411

08405

1. PLACE OF DEATH a. COUNTY Prince George's			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General			d. STREET ADDRESS 3708 38th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Paul Middle C Last Wallin			4. DATE OF DEATH Month 7- Day 27 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-82		9. AGE (In years last birthday) yrs 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. Agent		10b. KIND OF BUSINESS OR INDUSTRY Life Ins. Co.	11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME L.P.A. Wallin			14. MOTHER'S MAIDEN NAME Louisa Mithilda Erickson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 349032515	17. INFORMANT Mrs. Elvira W. Greenwood Address Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death due to DUE TO Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Edema due to Heart disease DUE TO Heart insufficiency (c) Heart insufficiency					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cottage City, Md.	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5:30 p.m. from the causes and on the date stated above					
22a. SIGNATURE George Hageage		M D	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-27-61	
22c. PHYSICIAN'S NAME (Type) George Hageage		22d. ADDRESS 3717 38th Ave. Cottage City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31/61	23c. NAME OF CEMETERY OR CREMATORY Ceder Hill cemetery		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE JUL 31 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



CERTIFICATE OF DEATH

Reg. Dist. No. 02406

8412

1 PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 11 yrs.		d. STREET ADDRESS 905 Somerset Pl.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EDWARD ERNEST WALTON		4. DATE OF DEATH July 20 1961	
5. SEX male	6. COLOR OR RACE Wh.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 29, 1907
9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY Eng'r Inspector.	
11 BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Walton		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 578-09-1425	
17. INFORMANT Address Wife - Mrs. Helen Walton - 905 Somerset Pl.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic - luectic heart disease DUE TO (c) Undet.		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 22, 1961, to July 20, 1961, that I last saw the deceased alive on July 17, 1961, and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE William F. Simpson, Jr. M.D. 6216 N.H. Ave N.E.		7/20/61	
PHYSICIAN'S NAME (Type) William F. Simpson Jr. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-61	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Silver Spring Md.
23 FUNERAL DIRECTOR'S SIGNATURE Frank Leiers Sons Co		24a. REC'D BY REGISTRAR DATE JUL 21 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

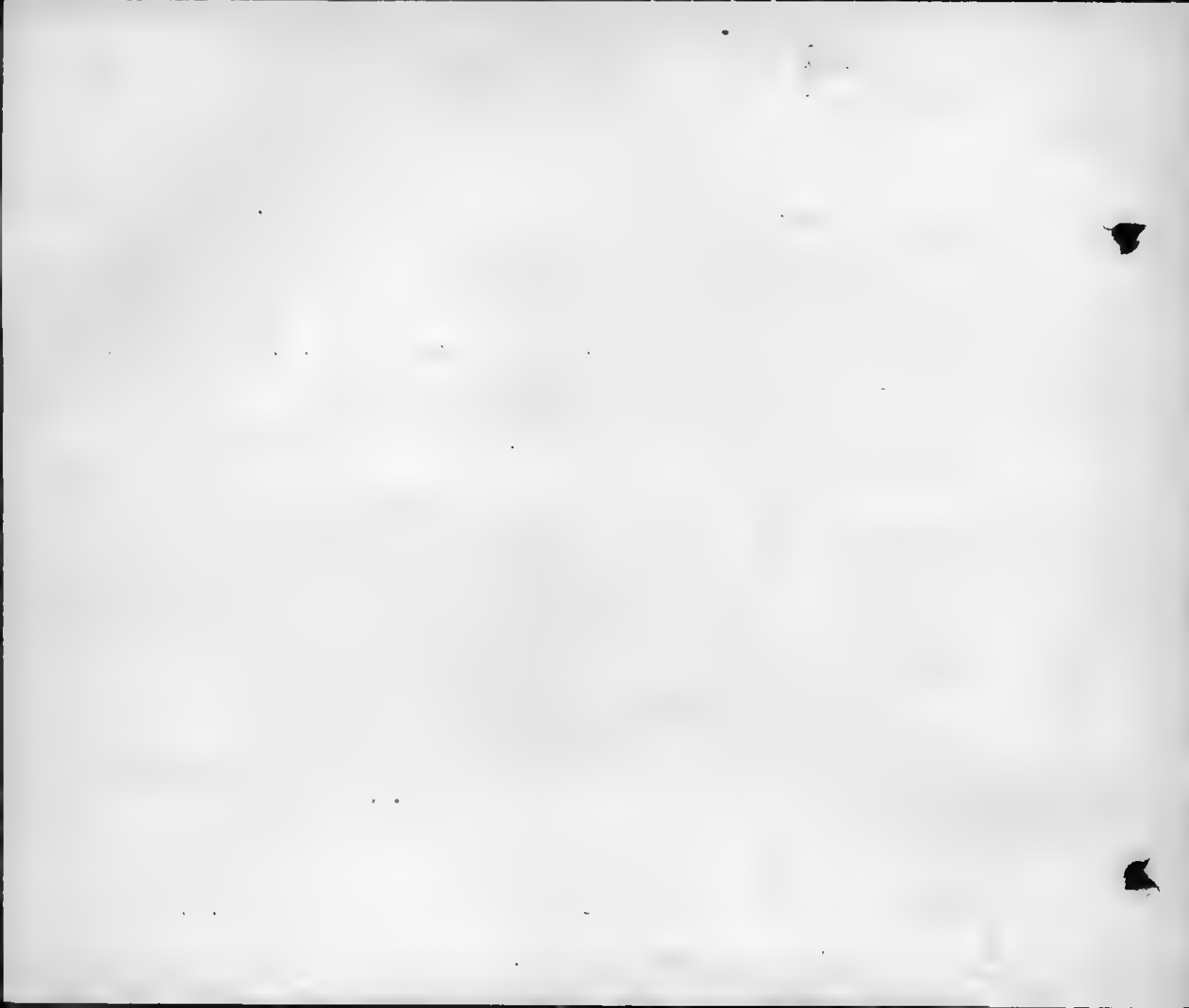
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15M 9/59

8413

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02407

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. STREET ADDRESS 4018 Jefferson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle M Last Weber		4. DATE OF DEATH Month July Day 26 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/67
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Augusta Metzler		14. MOTHER'S MAIDEN NAME Doris Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Doris Aman Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1 1961, to 7-26 1961, that (I) (we) last saw the deceased alive on 7-26 1961, and that death occurred at 11:40 from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis Gasch</u>		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type) Francis Gasch		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/61	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE JUL 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. By the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/59

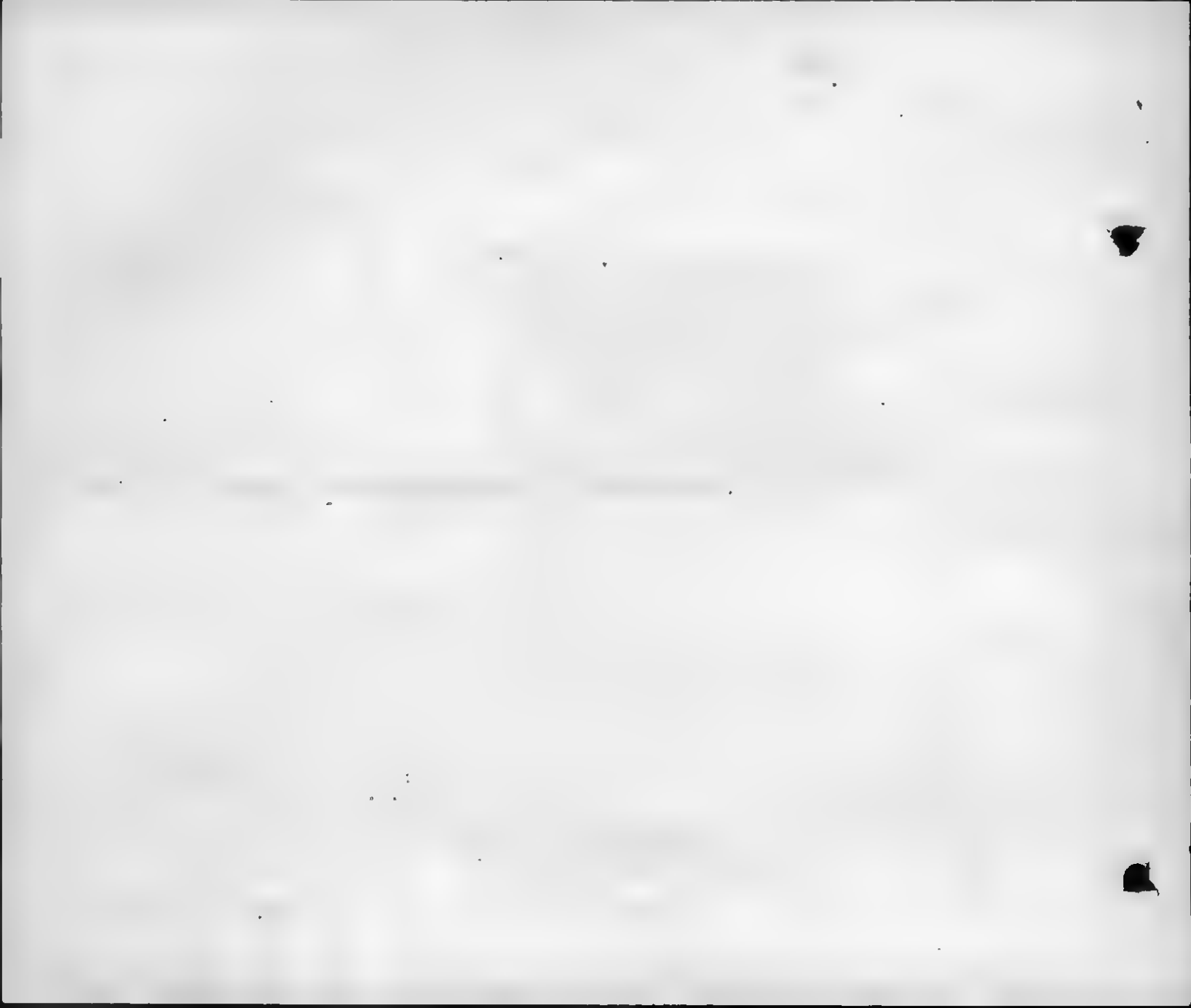
1
3
8414
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08408

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 11,810 Ellington Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clara Middle L. Last Weems				4. DATE OF DEATH Month 7 Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/91	9. AGE (In years lost birthday) 69 yrs	IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Smith				14. MOTHER'S MAIDEN NAME Lillian V. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Wilma C. Ross - 3520-Campbell NE Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, ACUTE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 36 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/5 1961 , to 7/5 1961 , that (I) (we) last saw the deceased alive on 7/5 1961 , and that death occurred on 7/5 1961 , from the causes and on the date stated above.							
22a. SIGNATURE Norman Donati Comenu M.D.				22b. DATE 7/6/61		22c. PHYSICIAN'S NAME (Type) Norman Donati Comenu	
22d. ADDRESS 3503 Penny St Mt Rainier Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORY Palmer Men.		23d. LOCATION (City, town, or county) (State) Murksboro Md	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Son ADDRESS 4925 Deane Ave NE				25a. REC'D BY REGISTRAR JUL 11 '61		25b. REGISTRAR'S SIGNATURE	

(M)

(I)

077



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

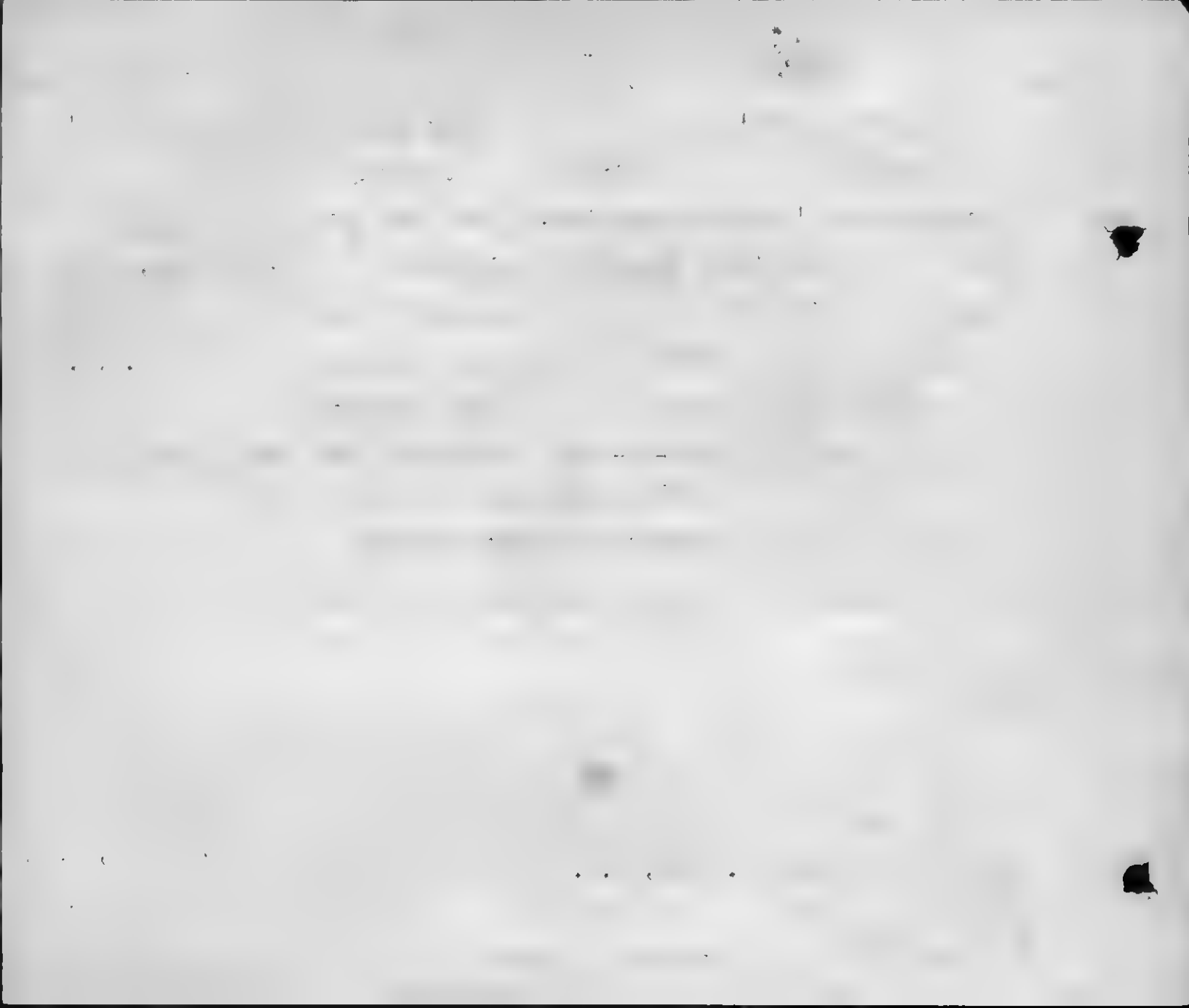
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8415

08409

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b Dead on arrival		d. STREET ADDRESS 3014 Parkway	
3. NAME OF DECEASED (Type or print) Francis Edward Weightman		4. DATE OF DEATH July 31, 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marble setter		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		9. AGE (In years last birthday) August 8, 1904 56 yrs.	
13. FATHER'S NAME Edmund L. Weightman		14. MOTHER'S MAIDEN NAME Anna Harris		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 577-09-1014		17. INFORMATION Leona Weightman same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured coronary infarct (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Interval BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accide. Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 31, 1961					
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county) Ft. Lincoln			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
22d. LOCATION (City, town, or country) Colmar Manor,		(State) Md.			
23. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE AUG 4 '61	
		24b. REGISTRAR'S SIGNATURE Anthony L. Thomas			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

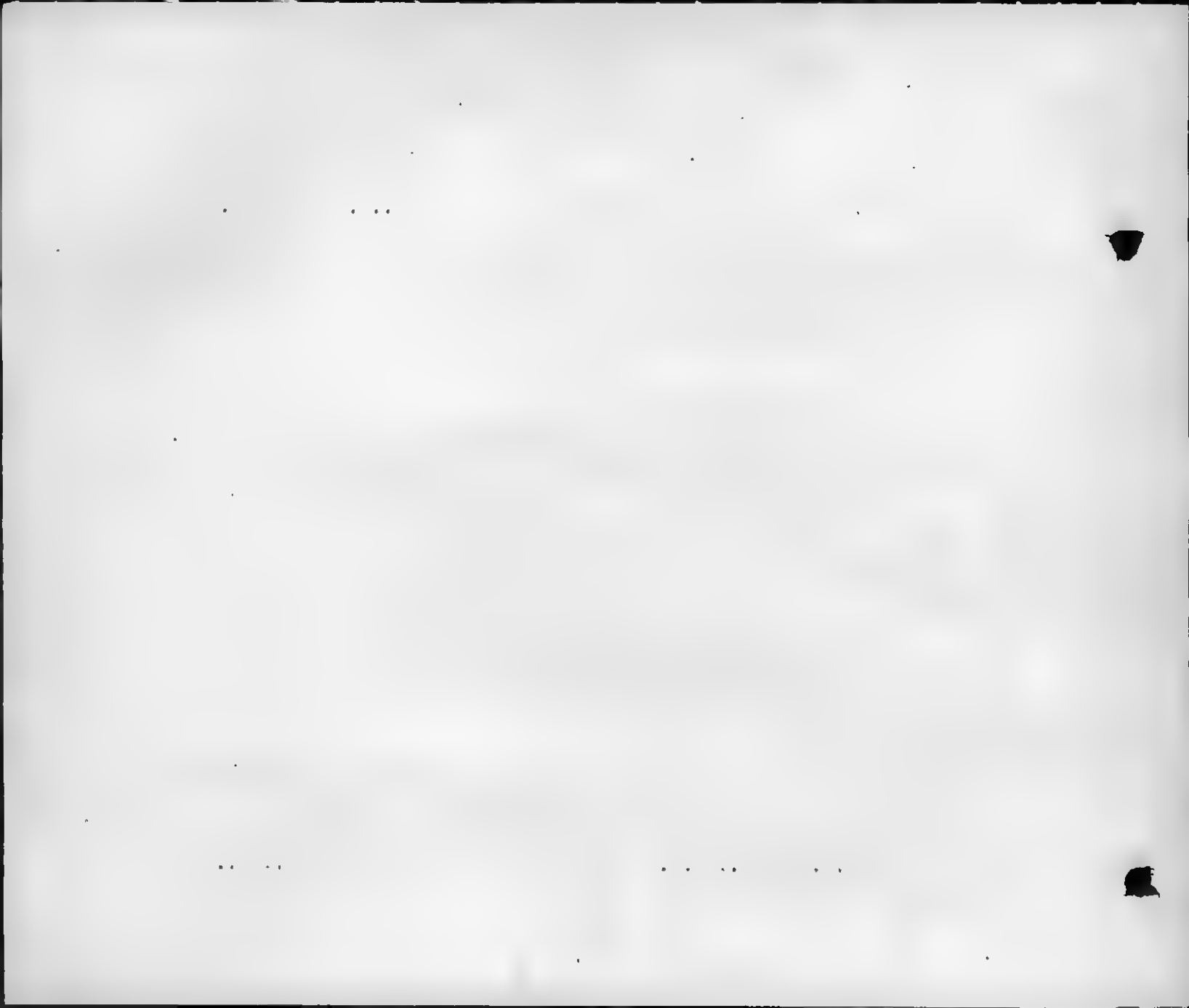
VR A15 (4)
15M 9/59

8416

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

084.0

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			d. STREET ADDRESS 8227 N.E. 1st Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clyde H Wells			4. DATE OF DEATH Month July Day 4 Year 19 61		
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 20 Mar 1890	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Advertising		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME James Wells			14. MOTHER'S MAIDEN NAME ? Peacock		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO.		
17. INFORMANT Robert P Wells			Address Hyattsville, Md.		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred 2:30 AM, from the causes and on the date stated above.					
22a. SIGNATURE Dr. A. Deitz, M.D.		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED July 4, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.		22d. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 7/6/61		23b. DATE THEREOF 7/6/61		23c. NAME OF CEMETERY OR CREMATORY Auburn	
23d. LOCATION (City, town, or county) New York		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur E. K...					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the medical director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the medical director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

Item 20 Film 290 7-17-61

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08411

1. PLACE OF DEATH
a. COUNTY **Prince George's**
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Prince George's General**

2. NAME OF DECEASED (Type or print) **Baby Boy Wills**

3. SEX **Male**

4. COLOR OR RACE **Colored**

5. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

6. DATE OF BIRTH **June 30, 1961**

7. AGE (In years last birthday) **2** IF UNDER 1 YEAR Months **2** Days **2** Hours **19** Min. **61**

8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

9. KIND OF BUSINESS OR INDUSTRY

10. BIRTHPLACE (State or foreign country) **Maryland**

11. CITIZEN OF WHAT COUNTRY? **U.S.A.**

12. FATHER'S NAME **John Douglas Wills**

13. MOTHER'S MAIDEN NAME **Claudia Wills**

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **15. SOCIAL SECURITY NO.** **16. INFORMANT** Address

17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Atelectasis to the lungs.**
(b) **Aspiration of Blood.**
(c) **Laceration to the pharynx.**

CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

18. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

19. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Was delivered spontaneously while the mother was standing up.**

20. TIME OF INJURY Month, Day, Year **7-1-61** Hour a.m. **9:30** p.m.

21. INJURY OCCURRED While at work ☐ Not While at work ☒

22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home**

23. (City or town) **Brandywine** (County) **P.G.** (State) **Md.**

24. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **James J. Boyd** M.D. DATE SIGNED **7/3/61**

EXAMINER'S NAME (Type) **James Boyd**

25. BURIAL, CREMATION, REMOVAL (Specify) **Cremation** 26. DATE THEREOF **7/19/61** 27. NAME OF CEMETERY OR CREMATORY **Prince George's Gen. Hosp. Cheverly, Md.** 28. LOCATION (City, town, or country) (State)

29. FUNERAL DIRECTOR **Harry W. Pennington** ADDRESS **24b. REC'D BY REG. STRAR** 30. REGISTRAR'S SIGNATURE **DATE JUL 13 '61** **Arthur S. Thomas**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

8418

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08412

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission on) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 4913 SHELBY DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CINDY ANN WILSON		4. DATE OF DEATH Month Day Year July 20 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 July 1961
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days 1 10 25	IF UNDER 24 HRS. Hours Min. 10 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME AUTHUR B WILSON	
14. MOTHER'S MAIDEN NAME DOROTHY LEE CONOVER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEDICAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESP. DISTRESS SYNDROME OF NEWBORN. DUE TO (b) PREMATURITY DUE TO (c) PREMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) INTERVAL BETWEEN ONSET AND DEATH: Birth 6:20p. Birth 6:40p.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from 18 JULY , 19 61 , to 20 JULY , 19 61 , that W (we) last saw the deceased alive on 20 JULY , 19 61 , and that death occurred at 210A , from the causes and on the date stated above.			
22a. SIGNATURE Arnold A. Abramo		22b. DATE SIGNED 20 JULY 1961	
22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO, Captain USAF MC USAF HOSPITAL, ANDREWS AFB, MARYLAND		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 24, 1961, Arlington Nat. Cemetery, VA		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Col. James H. Wilson		25a. REC'D BY REGISTRAR DATE JUL 26 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas		25c. ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 8/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

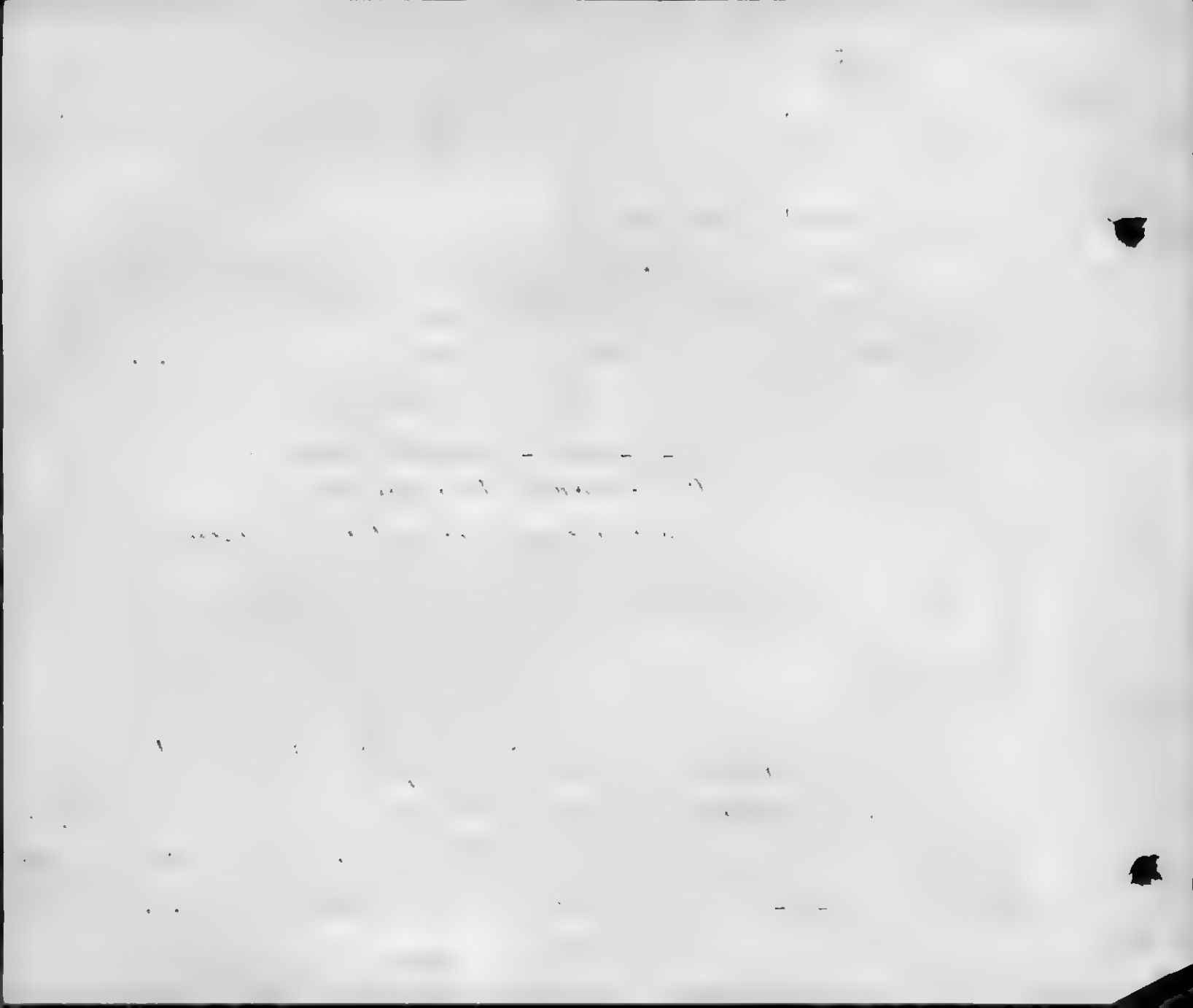
8419

CERTIFICATE OF DEATH

Item 9 Film G292 7/2/61 iwk

08413

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY in lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>4518-37th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Calenous</u>		4. DATE OF DEATH <u>July 25 1961</u>		9. AGE (In years, last birthday) <u>86</u> yrs.	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1875</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12a. USUAL BUSINESS OR INDUSTRY <u>Retired</u>		12b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>718-18-7309</u>	
17. INFORMANT <u>Margaret M. Bowles</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>7/25/61</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>61</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Margaret M. Bowles</u>		22b. ADDRESS <u>3503 Penny St Mt Rainier Md</u>		22c. DATE SIGNED <u>7/25/61</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	
23d. LOCATION (City, town or county) <u>Washington D.C.</u>		23e. REC'D BY REGISTRAR <u>JUL 28 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08414

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF DECEASED
(Type or print)

First

Henry

Middle

Last

Wohl

4. DATE OF DEATH

Month

July

Day

21

Year

19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

January 8, 1913 48

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give most of work done during most of working life, even if retired)

Economist

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Max Wohl

14. MOTHER'S MAIDEN NAME

Bessie Mishel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Helen Wohl Patterson Washington 20, D.C.

Address 1916 R Street S.E.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

011.7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PULMONARY EDEMA

Pending Barbiturate poisoning

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Coronary arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

July 21, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

7/23/61

22c. NAME OF CEMETERY OR CREMATORY

Mt. Lebanon Cem.

22d. LOCATION (City, town, or county)

Hyattsville

(State)

Md.

23. FUNERAL DIRECTOR

B. DANZANSKY & SONS

ADDRESS

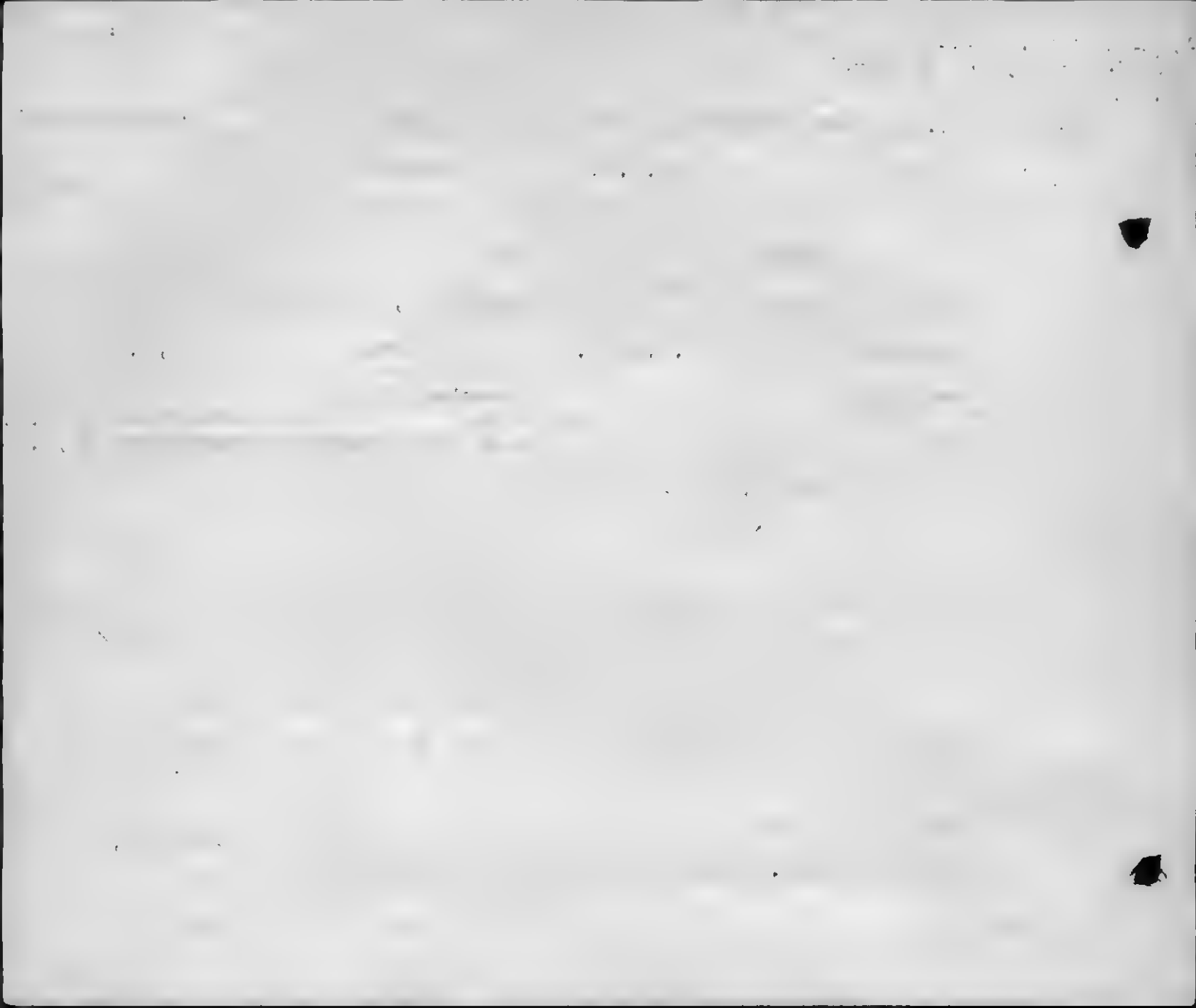
Wash. D.C.

24a. REC'D BY REGISTRAR

DATE JUL 25 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Hume



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

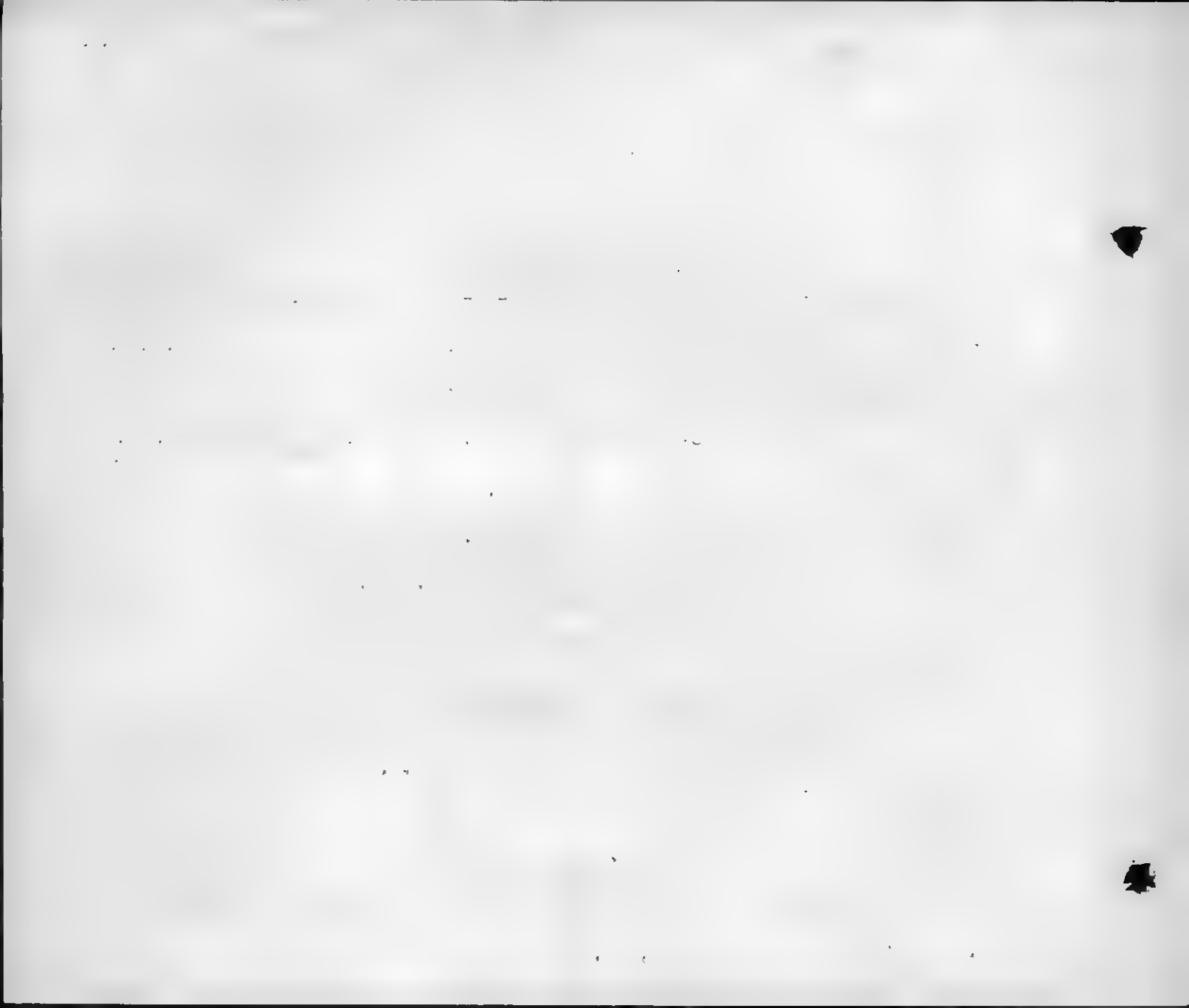
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8421

08415

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Forrestville		d. STREET ADDRESS 8330 Leona Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ashby Hamilton Wood		4. DATE OF DEATH Month Day Year July 28 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-17-14
9. AGE (In years last birthday) 46 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter Francis Wood		14. MOTHER'S MAIDEN NAME Anna Mae Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 223-16-5007	
17. INFORMANT Ruby S. Wood		Address 2215 Wyngate Rd. SE. Bradbury Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Purulent Meningitis (D. pneumonia) 24 hours			
+90 X DUE TO (b) Empyema, right lung (D. pneumonia) 48 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Lobar pneumonia, right lung. (D. pneumonia) 48 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25-61, 1961, that (I) (we) last saw the deceased alive on 7-26-61, 1961, and that death occurred at 9:32 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. C. Etienne		22b. DATE SIGNED 7-25-61	
22c. PHYSICIAN'S NAME (Type) W. C. Etienne		22d. ADDRESS College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/1/61	
23c. NAME OF CEMETERY OR CREMATORY Ceder Hill		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE AUG 3 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kears	



may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8422

08416

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b ? d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 7504 Finns Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Andrew Herman Woody				4. DATE OF DEATH Month Day Year July 28 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 25, 1884	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 77		11. IF UNDER 24 HRS Months Days Hours Min. 77		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chief (Purchasing Clerk) & Engraving				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Printing			
11. BIRTHPLACE (State or foreign country) Asheville, North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jack Woody				14. MOTHER'S MAIDEN NAME Elizabeth Hipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Bessie S. Woody- Address 7504 Finns Lane Lanham, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Pneumonia - hypostatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cerebral thrombosis with coma (c) DUE TO Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jun 58	
20f. (City or town) (County) (State) 28 Jul 1961				21. I certify that (I) (this hospital) attended the deceased from Jun 58 to Jul 28 1961 , that (I) (we) last saw the deceased alive on 27th 19 61 , and that death occurred on 28th AM, from the causes and on the date stated above			
22a. SIGNATURE Thomas G. Maloney				22b. DATE SIGNED 28 Jul 61		22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY	
22d. ADDRESS 4814-71st Ave.				23a. REC'D BY REGISTRAR DATE JUL 31 '61			
23b. REGISTRAR'S SIGNATURE Arthur S. Hines				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.				23e. DATE THEREOF 7/31/1961			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8423

08417

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Adelphi c. LENGTH OF STAY IN 1b 8 wks		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3311 Chauncey St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sophia Telores Wright		4. DATE OF DEATH Month Day Year July 17 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1882	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frederick Binck		14. MOTHER'S MAIDEN NAME Louise Bert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Nursing Home Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardio-Vascular Disease (c) Diabetic Mellitus (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal Insufficiency					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO INJURY			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan 1958 to July 17 1961, that (1) (we) last saw the deceased alive on July 17 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.					
22a. SIGNATURE R. H. Sandstrom M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-17-61	
22c. PHYSICIAN'S NAME (Type) R. H. Sandstrom		22d. ADDRESS 10202 Loriston Lane, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/20/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
23d. LOCATION (City, town or county) Washington D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines					

MEDICAL CERTIFICATION

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8424

08418

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkland d. STREET ADDRESS 229 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Inez Lucy Yeagley		4. DATE OF DEATH July 2 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/28/93		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 2 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Cusic		14. MOTHER'S MAIDEN NAME Lucy Graves		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT George Herbert		Address 229 Maryland Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-2-1961	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-5-1961		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l		22d. LOCATION (City, town, or country) (State) 22 Meyer, Va	
23. FUNERAL DIRECTOR Gabriel A Mattingly		ADDRESS 1311 11 St		24a. REC'D BY REGISTRAR W. S. D.		24b. REGISTRAR'S SIGNATURE Charles L. Hines	
DATE JUL 5 '61							

100-100000
100-100000

100-100000

(M)

(J)

Housewife
John Davis

same

same

John Davis

John Davis

John Davis

John Davis

John Davis